

IN THE COURT OF APPEALS

Appeal of the Decision of Administrative Law Court Judge Carolyn Matthews

Docket No. In the Lower Court 13-ALJ-08-0159-AP

Peter Brown,

Appellant

v.

South Carolina Department of Health and Human Services

Respondent.

EXHIBITS TO MEMORANDUM

Patricia Logan Harrison

611 Holly Street

Columbia, South Carolina 29205

803 256 2017

plh.cola@att.net

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**THE STATE OF SOUTH CAROLINA
In The Court of Appeals**

Peter Brown, Appellant,

v.

South Carolina Department of Health and
Human Services, Respondent.

Appeal From Administrative Law Court
Judge Carolyn C. Matthews

Opinion No. 4821
Heard February 9, 2011 – Filed April 20, 2011

REVERSED and REMANDED

Patricia Logan Harrison, of Columbia, for
Appellant.

Byron Ronald Roberts, of Columbia, for
Respondent.

FEW, C.J.: In this case we determine that the South Carolina Department of Health and Human Services (DHHS) has jurisdiction to decide an appeal from the termination of Medicaid waiver services. We reverse DHHS's and the Administrative Law Court's decisions to the contrary and remand for a hearing on the merits.

I. Facts and Medicaid Background

Peter Brown is a forty-three-year-old Medicaid recipient with mental retardation. He has related disabilities of epilepsy and diabetes. His IQ is 44, and his psychological evaluation places him at the juncture between the mild and moderate levels of mental retardation. He lives in Spartanburg, South Carolina at the Charles Lea Center, a supervised living arrangement for people with mental disabilities. Peter's expenses at the Center are paid with federal funds through Medicaid. Before Peter lived at the Center, he had been required under federal Medicaid law to live in an institutional intermediate care facility for

the mentally retarded (ICF/MR). In 1991, however, Peter began participating in a program that allowed him to move out of the ICF/MR institution and into the Center. Under this program, the United States Department of Health and Human Services waives the statutory requirement that individuals with mental disabilities live in an institution in order to receive money for Medicaid services.[1] This "waiver" program provides services to certain Medicaid recipients, like Peter, in a less restrictive setting, such as the Center.[2] The program saves money and improves the quality of life for Medicaid recipients by keeping them out of an institution.

Each state applies for approval of its customized waiver program by submitting a "waiver document" to the federal Centers for Medicare and Medicaid Services.[3] The South Carolina Department of Disabilities and Special Needs (DDSN) operates South Carolina's Mental Retardation/Related Disabilities (MR/RD) waiver, which specifically lists and defines the services it may provide to qualifying individuals.[4] The services provided under the waiver are intended to prevent an individual from regressing to the point of requiring institutionalization, and only a person who would otherwise qualify to live in an ICF/MR may receive waiver services.[5] Peter was allowed to forego institutionalization, and instead receives the residential habilitation waiver service through the Center. This includes services to help him meet his daily living needs at the Center such as cleanliness, chores, and food preparation.

Peter also received another Medicaid service—twelve hours per week of one-on-one service. However, that service is not listed in the waiver document. Peter's one-on-one service has been provided since 1992, when he was diagnosed with a pre-diabetic condition. The initial purpose of the service was to have someone with Peter to ensure he ate enough food and followed his diabetic diet. By the time the Center notified Peter of its intent to terminate the service in 2005, it included grocery help and community socialization activities. To manage his diabetes dietary restrictions, Peter has set menus and corresponding grocery lists for each week. The employee providing the one-on-one service helped Peter inventory his food supply and make a grocery list to match his weekly menu. The employee also helped Peter choose and attend activities in the community with non-disabled people.

II. Procedural History

In February 2005, the Center sent Peter's mother, Carolyn Brown, a letter notifying her of its intention to terminate Peter's twelve hours per week of one-on-one service.[6] In March 2005, Peter appealed the termination to DDSN. Based on its determination that the residential habilitation waiver service was "sufficient to meet Peter's needs," DDSN upheld the Center's decision to terminate the one-on-one service. DDSN's letter notifying Mrs. Brown of its decision stated: "Ultimately there has been no reduction or termination of MR/RD Waiver Services to Peter. Sufficient services and supports can be provided to Peter based on his assessed needs" In April 2005, Peter appealed the final DDSN agency decision to DHHS.

The DHHS hearing officer found as a matter of law that "if a service cannot be shown to keep a person out of an institutional facility for the mentally retarded, it is not a service covered by the Medicaid waiver." He then concluded: "If a service is not covered by Medicaid . . . it is not under the subject matter jurisdiction of a SCDHHS Hearing Officer." Applying that conclusion to Peter's complaint, the hearing officer determined he did not

have subject matter jurisdiction because Peter "has not met his burden of proof, by preponderance of the evidence, to establish that the one[-]on[-]one services are necessary to keep him out of an institution for the mentally retarded . . . and thereby establishing the subject matter jurisdiction of this Hearing Officer."

Peter appealed to the ALC. The ALC affirmed the hearing officer's decision, finding the one-on-one service is not a waiver service because it is not mentioned in the waiver document, and Peter did not show it is necessary to keep him out of an ICF/MR. Peter also argued his one-on-one service met the definition of the adult companion waiver service, and thus was covered by Medicaid and within the hearing officer's jurisdiction. The ALC rejected this argument. The ALC denied Peter's motion to alter or amend the judgment.

III. Jurisdiction

"Subject matter jurisdiction is the power to hear and determine cases of the general class to which the proceedings in question belong." Majors v. S.C. Sec. Comm'n, 373 S.C. 153, 159, 644 S.E.2d 710, 713 (2007). It refers to a tribunal's constitutional or statutory power to decide a case. Johnson v. S.C. Dep't of Prob., Parole, & Pardon Servs., 372 S.C. 279, 284, 641 S.E.2d 895, 897 (2007). "The question of subject matter jurisdiction is a question of law" Chew v. Newsome Chevrolet, Inc., 315 S.C. 102, 104, 431 S.E.2d 631, 631 (Ct. App. 1993).

Jurisdiction in this case is defined by federal and state regulations. When an individual believes his Medicaid-covered services or benefits have been wrongfully denied, terminated, suspended, changed, or reduced, he may appeal. 42 C.F.R. §§ 431.220(a)(1)-(2), 431.201 (2010); S.C. Code Regs. 126-380(A)-(B) (1992). The waiver document provides the right to appeal first to DDSN and then to DHHS. We find a DHHS hearing officer has subject matter jurisdiction to hear an appeal from the denial, termination, suspension, or reduction of a service or benefit which the individual alleges is covered by Medicaid. The jurisdiction of any tribunal is determined by the allegations, not by the answer to the questions raised by the allegations. See 21 C.J.S. Courts § 17 (2006) ("If the pleadings contain sufficient matter to challenge the attention of the court, and such a case is thereby presented as to authorize the court to deliberate and act, this is sufficient for the purpose of conferring jurisdiction. Thus, if a complaint sets forth a case belonging to the general class over which the authority of the court extends, the fact that it fails to state a cause of action does not affect the jurisdiction of the court."). Here, Peter alleges his one-on-one service is covered by Medicaid. Because jurisdiction is determined by the question to be answered, not by the answer itself, DHHS is the proper tribunal to determine whether he is correct.

Nevertheless, the ALC and DHHS hearing officer found Peter's one-on-one service is not covered by Medicaid as a waiver service because Peter did not prove it was necessary to keep him out of an institution. This supposed requirement comes from the following statement in the waiver document:

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, . . . : Intermediate care facility for mentally retarded or persons with related disabilities (ICF/MR).

From this statement, the hearing officer determined "if a service cannot be shown to keep a person out of an institutional facility for the mentally retarded, it is not a service covered by the Medicaid waiver" and therefore outside of his jurisdiction. On appeal, Peter argues the hearing officer erred in requiring him to prove that he would immediately be returned to an ICF/MR facility if his one-on-one service was terminated. We agree.

The statement that the ALC order cites is not intended to provide a legal standard for establishing jurisdiction. Rather, a person must first qualify as one who would require institutionalization without the availability of the waiver-provided services, but is not also required to show that *each* waiver service provided prevents him from institutionalization. For example, the waiver provides for "Prevocational services," which "are aimed at preparing an individual for paid or unpaid employment Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety." It is highly unlikely a person would need to be institutionalized absent prevocational skills; however, they are provided under the waiver. To read the document as the ALC interpreted it would necessitate a waiver-qualifying individual to prove that each service he requested was necessary to avoid institutionalization. The ALC erred by imposing upon Peter an incorrect legal standard to establish jurisdiction.

Finally, the ALC noted "one-on-one services are not 'waiver services' . . . over which the DHHS hearing officer would have subject matter jurisdiction" because "[t]he waiver document does not mention one-on-one services" and "there is sworn testimony in the record . . . that one-on-one services are not MR/RD Waiver services." Peter argues the service was covered under the waiver because it met the definition of the adult companion waiver service. We do not reach the question of whether the service qualifies as a waiver service. We note, however, that the answer to the question is not controlled by whether the service is labeled as one-on-one as opposed to adult companion services.

IV. Conclusion

We reverse the ALC's conclusion that the hearing officer did not have subject matter jurisdiction to hear Peter's appeal and its application of an incorrect legal standard. Accordingly, the remainder of the order is vacated, and the case is remanded to DHHS for a hearing on the merits in accordance with this opinion and pursuant to 42 C.F.R. § 431.220(a)(1)-(2).

REVERSED and REMANDED.

THOMAS and KONDUROS, JJ., concur.

[1] 42 U.S.C. § 1396n(c) (Supp. 2010); 42 C.F.R. § 441.300 (2010); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007).

[2] See S.C. Code Ann. § 44-20-20 (2002) ("It is the purpose of this chapter to assist persons with mental retardation . . . by providing services to enable them to participate as valued members of their communities to the maximum extent practical and to live . . . in the least restrictive environment available.").

[3] 42 C.F.R. §§ 440.180(b), 431.55 (2010).

[4] S.C. Code Ann. § 44-20-270 (2002).

[5] The services provided and descriptions of them are found in the MR/RD Waiver Document (effective Oct. 1, 2004-Sept. 30, 2009) (on file with SCDDSN).

[6] Peter is also a plaintiff in an action proceeding simultaneously in federal court that alleges DHHS and DDSN violated the Americans with Disabilities Act and other federal statutes. Peter B. v. Sanford, No. 6:10-cv-00767-JMC (D.S.C. Mar. 7, 2011). On March 7, 2011, the United States District Court for the District of South Carolina granted the plaintiffs a temporary injunction prohibiting the defendants from reducing or terminating certain Medicaid services. As a result, Peter is currently receiving his one-on-one service.

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)
))
))
P. B.,)
))
Petitioner,)
))
-v-)
))
State Department of Health)
and Human Services,)
))
Respondent.)
_____)

BEFORE THE HEARING OFFICER
OF THE STATE DEPARTMENT OF
HEALTH AND HUMAN SERVICES

RESPONDENT'S
PREHEARING BRIEF
15-MISC-015
(MR/RD Waiver)

TO: Ms. Janet R. Goode, Hearing Officer South Carolina Department of Health and Human Services, P. O. Box 8206, Columbia, SC 29202-8206 AND Patricia Harrison, Esquire, 611 Holly Street, Columbia, SC 29205

Issues on Appeal

Petitioner is an individual eligible for Medicaid, who receives home and community based services through the Intellectual Disabilities/Related Disabilities (ID/RD) Waiver. The ID/RD Waiver is a Medicaid waiver managed by SCDHHS, which has delegated the day to day operations of the waiver to the South Carolina Department of Disabilities and Special Needs (DDSN). One of the services available through the ID/RD waiver is Residential Habilitation Services (RHS). Petitioner has been a recipient of RHS. Petitioner also received twelve (12) hours of "one-on-one" services. In 2005, Petitioner received a notice of termination of the "one-on-one" services and timely appealed, first to the Director of DDSN, and then to the Appeals and Hearing Division. When this case was originally appealed in 2005, DHHS assigned a Hearing Officer and a hearing was begun on August 9, 2005, continued on August 10, 2005 and concluded on October 19, 2005. Petitioner contended that the "one-on-one" services are Adult

Companion Services (ACS) which are available through the ID/RD Waiver. Respondent contended that the services were not Waiver services and further, whether defined as ACS or not, were duplicative of the services Petitioner received through RHS. The Hearing Officer determined that the Division of Appeals and Hearings did not have subject matter jurisdiction. The Administrative Law Court upheld the Hearing Officer's decision on appeal, deciding that DHHS lacked subject matter jurisdiction and that the "one-on-one" services were duplicative of the RHS services. Ultimately, the South Carolina Court of Appeals determined that the DHHS Division of Appeals and Hearings does have jurisdiction and that the answer to the question of whether the "one-on-one" service is a Medicaid service is not controlled by whether the service is labeled as "one-on-one" as opposed to ACS. The Court of Appeals reversed and remanded the case to the DHHS Division of Appeals and Hearings for a hearing on the merits. Therefore, the sole issues on appeal are whether or not the "one-on-one" service is a Medicaid service and whether or not the Petitioner needs such services in addition to RHS.

Respondent's Position

Based solely upon the cost to DHHS of continuing this litigation, DHHS is not contesting the case on the merits. After considering the cost of litigating this matter further, DHHS has decided to not contest Petitioner's assertion that the "one-on-one" service is a Medicaid service, ACS, and that Petitioner meets criteria for and is appropriate for ACS.

As a result of not contesting the case on the merits, Respondent agrees that, as an ID/RD Waiver participant, Petitioner will be allowed to receive ACS offered by the ID/RD Waiver, provided by the qualified provider of his choice, in the same amount, duration, and scope as Petitioner received "one-on-one-services" at the time of his appeal in 2005. Of course, all Waiver participants, including Petitioner, are evaluated yearly under 42 CFR §441.302(c)(2), but any reduction in Petitioner's authorization would be subject to appeal.

This being the Respondent's position, there remains no issue for adjudication and, therefore, there is no need for a hearing. To the extent that issues are raised such as the provider's communications with the Petitioner's Guardian, specific types of vehicles used to provide the services, the provider's access to Petitioner's health records, and any issue other than Petitioner's need for one-on-one/ACS services, Respondent submits that these issues are not before this tribunal in this appeal. The services which Petitioner has asked for, and to which Respondent has agreed he is entitled, are Adult Companion Services, defined in the Waiver as:

Service Definition (Scope): 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 diversional in nature. Reimbursement will not be made to any family members residing in the same residence as the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Up to 28 hours per week based on SCDDSN assessed need. When Adult Companion is authorized in conjunction with Adult Attendant and /or Personal Care 2, the combined total hours per week of services cannot exceed 28. One unit of service equals one hour provided by one Companion worker. (see attached Waiver pages 61-62)

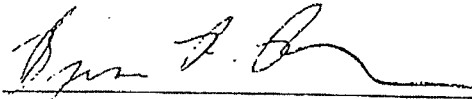
After considering the cost of litigating this matter further, DHHS has decided to not contest Petitioner's assertion that the "one-on-one" service is a Medicaid service, ACS, and that the Petitioner meets criteria for and is appropriate for ACS.

THEREFORE, there being no issue remaining for adjudication, the Respondent requests that the Hearing be cancelled and the Hearing Officer issue an Order as follows:

As an ID/RD Waiver Participant, Petitioner is allowed to receive ACS offered by the ID/RD Waiver, provided by the qualified provider of his choice, in the same amount,

duration, and scope as Petitioner received one-on-one services at the time of his appeal in 2005.

Respectfully submitted,



Byron R. Roberts
General Counsel
South Carolina Department
of Health and Human Services
Post Office Box 8206
Columbia, South Carolina
29202-8206
(803) 898-0218
Fax (803) 255-8210
Attorney for the Respondent

Columbia, South Carolina
March 7, 2013

Provider Category	Provider Type Title
Individual	Independent Attendant Care Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Attendant Care Services

Provider Category:

Individual

Provider Type:

Independent Attendant Care Providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Scope of Service as defined in the UAP/SCDDSN Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN/UAP

Frequency of Verification:

Upon enrollment/Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Companion Services

Service Definition (Scope):

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 diversional in nature. Reimbursement will not be made to any family members residing in the same residence as the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Up to 28 hours per week based on SCDDSN assessed need. When Adult Companion is authorized in conjunction with Adult Attendant and /or Personal Care 2, the combined total hours per week of services cannot exceed 28. One unit of service equals one hour provided by one Companion worker.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☒ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DSN Boards/contracted providers for Adult Companion providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Adult Companion Services

Provider Category:

Agency

Provider Type:

DSN Boards/contracted providers for Adult Companion providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

SCDDSN Adult Companion Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDDSN

Frequency of Verification:

Upon enrollment and QIO Reviews are conducted on a 12-18 month cycle, depending on past provider performance.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Day Health Care Nursing

Service Definition (Scope):

Adult Day Health Care Nursing Services are provided in and by the adult day health care center and are limited to the

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

TELEPHONE (803) 256-2017

FAX (803) 256-2213

March 8, 2013

The Honorable Janet Goode
SC Department of Health and Human Services
Office of Appeals and Hearings
PO Box 8206
Columbia, SC 29202-8206

Re: Peter Brown

Dear Judge Goode:

Enclosed is our pre-trial brief which was delivered March 7, 2013, via e-mail.

Sincerely,

Patricia Harrison, by MCL

Patricia L. Harrison

cc: Byron Roberts, Esquire
Sandra Ray, Esquire
Ken Anthony, Esquire
Mrs. Carolyn Brown



CERTIFIED SPECIALIST IN ESTATE PLANNING AND PROBATE LAW

In the Office of Hearings and Appeals of
the South Carolina Department of Health and Human Services

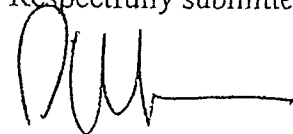
Fair Hearing of Peter Brown v. DHHS
Case No. 05-MISC-015 (MR/RD Waiver)

Appellant's Pretrial Brief

Federal regulations contained at 431.243 provide that hearing decisions must be based exclusively on evidence introduced at the hearing and that a final determination must be issued within 90 days from the date the participant requested a fair hearing. Appellant has alleged that DHHS is in violation of federal regulations and has requested a fair hearing. An appeal may not be dismissed unless the appellant requests dismissal or fails to appear at a scheduled hearing without good cause.

The Appellant asserts that the agency has not only violated the reasonable promptness requirements of the Medicaid Act, but that the agency has erred by basing its decision to terminate Peter's one-on-one or companion services on erroneous grounds and that it has failed to provide medically necessary services. All allegations previously made by Appellant during the course of these proceedings are herein realleged, including the allegations that these services were terminated in retaliation for acts by Peter's guardian and other advocates.

Respectfully submitted,



Patricia L. Harrison



In the Office of Hearings and Appeals of
the South Carolina Department of Health and Human Services

Fair Hearing of Peter Brown v. DHHS
Case No. 05-MISC-015 (MR/RD Waiver)

Appellant's Pretrial Brief

Federal regulations contained at 431.243 provide that hearing decisions must be based exclusively on evidence introduced at the hearing and that a final determination must be issued within 90 days from the date the participant requested a fair hearing. Appellant has alleged that DHHS is in violation of federal regulations and has requested a fair hearing. An appeal may not be dismissed unless the appellant requests dismissal or fails to appear at a scheduled hearing without good cause.

The Appellant asserts that the agency has not only violated the reasonable promptness requirements of the Medicaid Act, but that the agency has erred by basing its decision to terminate Peter's one-on-one or companion services on erroneous grounds and that it has failed to provide medically necessary services. All allegations previously made by Appellant during the course of these proceedings are herein realleged, including the allegations that these services were terminated in retaliation for acts by Peter's guardian and other advocates.

Respectfully submitted,

Patricia L. Harrison



Janet Goode

From: Janet Goode
Sent: Monday, March 11, 2013 9:13 AM
To: Byron Roberts (Robertsb@scdhhs.gov); plh.cola@att.net; plh.cola@worldnet.att.net
Subject: 05-MISC-015 Peter Brown [secure]

Ms. Harrison and Mr. Roberts,

On March 7, 2013, I received Prehearing Briefs from both of you. I have reviewed the briefs and I have taken into consideration arguments given in both briefs. I once again reviewed the Order of Remand from Judge Few and the sole issues addressed in the Remand. I have closely compared the arguments given in the Prehearing Briefs and the issues that Judge Few very clearly stated in his Order of Remand.

I have determined a hearing in these matters are moot. Therefore, the hearing that was continued to Wednesday, March 13, 2013 upon request of continuation at the original hearing on November 13, 2012 for possible resolution at the parties is cancelled. My Order of Dismissal in this matter is forth coming and should be sent within the week.

Sincerely,

Janet R. Goode, Hearing Officer
Division of Appeals and Hearings
SC Dept. of Health and Human Services
PO Box 8206
1801 Main Street, Suite 906
Columbia, SC 29202-8206
(803) 898-2600
(803) 898-8206 (Fax)
goodej@scdhhs.gov

ORDER OF DISMISSAL IN
THE APPEAL MATTER OF
P.B. (PETITIONER) v. SCDHHS (RESPONDENT)

Appeals' Case #05-MISC-015 (MR/RD Waiver)
Medicaid # 5727764401
Hearing Date: Not held

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. 44-6-10, et seq.). This appeal has been 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.).

ISSUE

The issues, based on Order of Remand from Judge C. Few, South Carolina Court of Appeals, are whether or not the "one-on-one" service is a Medicaid service and whether or not the Petitioner needs such services in addition to Residential Habilitation Services (RHS). Any issues raised in the proceedings or hearing of this case but not addressed in this Decision are deemed denied.

BACKGROUND

Petitioner is an individual eligible for Medicaid, who receives Home and Community Based Services (HCBS) through the Mental Retardation/Related Disabilities Waiver (MR/RD) Waiver. The Waiver has been changed to Intellectual Disabilities/Related Disabilities (ID/RD) Waiver. The Waiver was MR/RD at the time of appeal in 2005. The MR/RD Waiver is a Medicaid Waiver managed by South Carolina Department of Health and Human Services (SCDHHS). SCDHHS has delegated the day to day operations of the waiver to the South Carolina Department of Disabilities and Special Needs (SCDDSN). Petitioner has been a recipient of one of the services available through the MR/RD waiver; specifically Residential Habilitation Services (RHS) through the Supervised Living Program. In addition to being a recipient of RHS, Petitioner also received twelve (12) hours of "one-on-one" services. In March 2005, Petitioner's mother request for reconsideration to SCDDSN for the proposed termination of Petitioner's one-on-one services resulted in SCDDSN upholding the initial determination to terminate Petitioner's one-on-one services. On April 4, 2005, Petitioner's Representative, Patricia L. Harrison timely appealed the reconsideration denial. A hearing in this matter began on August 9, 2005, continued on August 10, 2005 and concluded on October 19, 2005. Hearing Officer, Barry Streeter, Esquire (retired) rendered a decision on December 29, 2006 determining SCDHHS lacked subject matter jurisdiction that in the matter. Petitioner's Representative appealed the Hearing Officer's decision to the Administrative Law Court (ALC). The ALC upheld the Hearing Officer's decision on appeal, deciding DHHS lacked subject matter jurisdiction and that the one-on-one services were duplicative of the RHS services. Petitioner's Representative

appealed the ALC decision to the South Carolina Court of Appeals. Judge C. Few, South Carolina Court of Appeals reversed and remanded the case to the DHHS Division of Appeals and Hearings for a hearing on the merits with the sole issues on appeal being whether or not the "one-on-one" service is a Medicaid service and whether or not the Petitioner needs such services in addition to RHS. On December 16, 2011, Order of Remand was received in the Division of Appeals and Hearings and assigned to a Contract Hearing Officer as the original Hearing Officer had since retired. In July of 2012, the Contract Hearing Officer returned the case to the Division of Appeals and Hearings with no action taken on the case. The appeal was reassigned to the undersigned Hearing Officer on July 24, 2012. The undersigned Hearing Officer reviewed the Remand Order and evidence of record (ten (10) bound volumes) from the 2005 hearing. Via email of August 28, 2012, Attorneys for both parties were notified of the reassignment of the appeal to the undersigned Hearing Officer. Attorneys were requested to respond to the undersigned Hearing Officer by August 31, 2012 with proposed, agreed upon hearing dates for the hearing with the month of November open on the undersigned Hearing Officer's calendar. Upon receipt of agreed upon dates, Notice of Hearing was sent. On November 13, 2012, Petitioner's mother and Attorneys for both parties timely arrived for the scheduled hearing. Approximately 30 minutes prior to the hearing, Petitioner's mother and Attorney for the Petitioner met outside of the Hearing Officer's and Attorney for Respondent's presence. Respondent's Attorney was called into the meeting with the Hearing Officer not present. The Hearing Officer presented to the conference room when summoned. Attorneys informed the Hearing Officer the parties were close to settling and requested additional time for Petitioner's Attorney to present additional documents to Respondent's Attorney. Respondent's Attorney stated he had to consult with his client before agreeing to settlement. Both parties were given to December 6, 2012 to notify the Hearing Officer as to whether resolution had been achieved. The Attorneys requested an extension to December 6, 2012 stating they were continuing with good faith negotiations in an attempt to resolve the case without a hearing. On January 25, 2013, via email, the Hearing Officer was notified mutual resolution was not met. Based on the Hearing Officer's calendar, dates for rescheduling the hearing were proposed with the parties agreeing on March 12, 2013 and March 13, 2013. On February 4, 2013, Notice of Hearing was sent. On February 26, 2013 correspondence from the Respondent's Attorney was received by the undersigned Hearing Officer requesting each party be given the opportunity to submit proposed orders for the Hearing Officer's consideration with there being no need for a hearing because the Respondent had decided not to contest the case on the merits. The Hearing Officer offered to accept a Consent Order signed and dated by both Attorneys or the hearing in the matter would be held as scheduled. On March 6, 2013, Robert French, Chief Hearing Officer called with the Attorneys present, requesting the hearing scheduled for March 12, 2013 be moved to March 13, 2013 with an additional day given to submit Prehearing Briefs. Request was granted. On March 7, 2013, both parties submitted Prehearing Briefs.

Prehearing Brief from Attorney for the Petitioner argues federal regulations at "431.243". The Hearing Officer found this regulation to be irrelevant to this appeal. However, the Hearing Officer found it obvious, based on the context of the brief, that federal regulation at 431.244 was the Attorney's intended reference. Attorney further argued in addition to Respondent's violation of reasonable promptness requirements of the Medicaid Act, Respondent erred by basing the decision to terminate Petitioner's one-on-one companion services on erroneous grounds and failed to provide medically necessary services. Attorney concluded stating all allegations

previously made by the Petitioner during the course of these proceedings are realleged to include the allegations that Petitioner's services were terminated in retaliation for acts by Petitioner's guardian and other advocates.

Prehearing Brief from Attorney for the Respondent provided a history of the case and presented Respondent's Position. Respondent's Attorney states Respondent is not contesting the case on the merits and after considering litigation cost in continuing this matter, the Respondent has decided not to contest Petitioner's assertion that the "one-on-one" service is a Medicaid service, ACS, and that Petitioner meets criteria for and is appropriate for ACS. In not contesting the case on the merits, Respondent's Attorney states Respondent agrees that as an ID/RD Waiver participant, Petitioner will be allowed to receive ACS offered by the ID/RD Waiver, provided by the qualified provider of his choice, in the same amount, duration, and scope as Petitioner received "one-on-one" services at the time of his appeal in 2005. Respondent's Attorney requested cancellation of the scheduled hearing arguing no issue remains for adjudication.

FINDINGS OF FACT AND CONCLUSION OF LAW

I make the following Findings of Fact by a preponderance of the evidence:

- (1) Based on the evidence of record in Petitioner's file, Hearing Officer, Barry Streeter requested a Psychological evaluation after the hearing that concluded on October 19, 2005. The Psychological evaluation was performed on January 26, 2006 and sent to both parties for comment on March 6, 2006. Mr. Streeter rendered a decision in this matter on December 29, 2006 (See, Case File);
- (2) On February 6, 2007 Petitioner's Representative filed a Notice of Appeal with the ALC (See, Case File);
- (3) On May 12, 2009, the Honorable Carolyn C. Matthews issued an order upholding the SCDHHS Hearing Officer's final Decision that SCDHHS did not have subject matter jurisdiction. Judge Matthews also held that the one-on-one services the Petitioner was receiving were a duplication of RHS that Petitioner was simultaneously receiving under the MR/RD Waiver. On appeal, the South Carolina Court of Appeals, Judge C. Few reversed the ALC's conclusion that the Hearing Officer did not have subject matter jurisdiction to hear the Petitioner's appeal and its application of an incorrect legal standard. The case was remanded to Division of Appeals and Hearings, SCDHHS for a hearing on the merits (See, Case File);
- (4) On December 20, 2011, Order of Remand was received in the Division of Appeals and Hearings and assigned to a Contract Hearing Officer (See, Case File);
- (5) In July 2012, the Contract Hearing Officer returned the case to the Division of Appeals and Hearings with no evidence of action taken on the case (See, Case File);

Conclusion of Law: 42 CFR 431.244 states "(f) The agency must take final administrative actions as follows; (1) Ordinarily, within 90 days from the earlier of the following....".

The case file offers no explanation for the lack of reasonable promptness in any action taken by individuals prior to the case being assigned to this Hearing Officer. The argument by the Petitioner's Attorney is not an issue addressed in the Order of Remand from Judge C. Few.

- (6) The undersigned Hearing Officer was assigned the appeal on July 24, 2012 with actions taken as timely as possible while allowing a hearing continuation and multiple extensions as it was determined good faith effort was being given by the parties in the attempt to reach resolution without the need for a hearing (See, Case File);
- (7) On March 7, 2013, both Attorneys for both parties submitted a Prehearing Brief (See, Case File);
- (8) Prehearing Brief submitted by the Attorney for the Respondent states the Respondent is not contesting the case on the merits and has decided not to contest Petitioner's assertion that the "one-on-one" service is a Medicaid service, ACS, and that Petitioner meets criteria for and is appropriate for ACS. Attorney for the Respondent requests cancellation of the Hearing with the Petitioner allowed to receive ACS offered by the ID/RD Waiver, to be provided by the qualified provider of his choice, in the same amount, duration and scope as Petitioner received one-on-one services at the time of his appeal in 2005(See, Case File);
- (9) Prehearing Brief submitted by the Attorney for the Petitioner argues the Petitioner alleges Respondent is in violation of federal regulations and has requested a fair hearing that may not be dismissed unless the Petitioner requests dismissal or fails to appear at a scheduled hearing without good cause. Attorney asserts the Respondent has erred by basing its decision to terminate the Petitioner's one-on-one or companion services on erroneous grounds with the Respondent failing to provide medically necessary services. In addition, Petitioner's Representative states all allegations previously made by the Petitioner during the course of these proceedings are realleged to include the allegations that Petitioner's services were terminated in retaliation for acts by Petitioner's guardian and other advocates (See, Case File);
- (10) The issues of remand as set forth in Judge C. Few's Order, whether or not the "one-on-one" service is a Medicaid service and whether or not the Petitioner needs such services in addition to RHS, are moot based on Respondent's decision not to contest the case on the merits and agrees that the Petitioner as an ID/RD Waiver participant will be allowed to received ACS offered by the ID/RD Waiver, provided by the qualified provider of his choice, in the same amount, duration, and scope as the Petitioner received "one-on-one" services at the time of Petitioner's appeal in 2005.

Conclusion of Law: A Hearing Officer has the authority to dismiss an appeal pursuant to Department of Health and Human Services' regulations on Appeals and Hearings §126-154 which states, "A Hearing Officer has the authority, among other things, to: direct all procedures; issue interlocutory orders, schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of

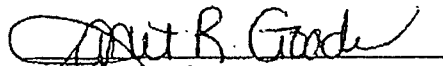
briefs and/or proposed findings of fact and conclusions of law; call witnesses and cross examine any witnesses; recess, continue and conclude any proceedings; dismiss any appeal for failure to comply with requirements under this Subarticle."

Conclusion of Law: The dismissal of this appeal is proper as it is moot and does not present a justiciable controversy as supported by 27 S.C. Code Ann. Regs 126-155 which states, "Generally, a court may conclude a matter that becomes moot and does not present a justiciable controversy. Sloan v. Friends of the Henley, Inc. 369 S.C. 20.630 S. E. 2d 474 (2006). A moot case exists where a judgment rendered by the court will have no practical legal effect upon an existing controversy because an intervening event renders any grant of effectual relief impossible for the reviewing court. Sloan, Id, citing Mathis v. South Carolina Highway Dep't. 260 S.C. 344, 195 S.E. 2d 713 (1973). Nevertheless, even though an issue has become moot, the court may still review the issue, if the action complained of is 1) capable of being repeated without review and 2) is a matter of important public interest. Curtis v. State of South Carolina. 345 S.C. 557m 549 S.E. 2d 591 (2001) as quoted in Sloan, Id. See also Commissioners of Public Works v. South Carolina Department of Health and Environmental Control. 372 S.C. 351.641 S.E. 2d 763 (2001).

DECISION

Based on the Findings of Fact and Conclusions of Law, there being no issue remaining for adjudication, the Hearing in this matter is cancelled and this matter is **DISMISSED**. As an ID/RD Waiver Participant, Petitioner is allowed to receive ACS offered by the ID/RD Waiver, provided by the qualified provided of the Petitioner's choice, in the same amount, duration, and scope as Petitioner received one-on-one services at the time of Petitioner's appeal in 2005.

AND IT IS SO ORDERED.


Janet R. Goode
Hearing Officer

DATED AT COLUMBIA,
South Carolina

March 12, 2013

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Peter Brown,	)	
	)	Docket No. 13-ALJ-08-0159-AP
Appellant,	)	
	)	
v.	)	
	)	DECISION AND ORDER
South Carolina Department of Health	)	
and Human Services,	)	
	)	
Respondent.	)	
	)	

APPEARANCES: Patricia L. Harrison, Attorney for Appellant
Kenneth P. Woodington, Attorney for Respondent

FACTS AND PROCEDURAL BACKGROUND

On March 12, 2013, a Hearing Officer for the South Carolina Department of Health and Human Services ("DHHS") dismissed this action as moot after DHHS advised the Hearing Officer that based on litigation costs, the Department would no longer contest this case on its merits. This appeal followed.

The case originated with a 2005 administrative appeal by Appellant Peter Brown from a decision by the Department of Disabilities and Special Needs (DDSN) to terminate twelve hours per week of certain services that Appellant had been receiving. As Appellant's attorney advised the DHHS Hearing Officer in 2005, "the only issue currently on appeal before the Division of Appeals and Hearings, is the agency's proposed reduction of twelve hours of services which are needed weekly. . . ."

The case was originally tried by the DHHS Hearing Officer for three days in 2005. The Hearing Officer ultimately dismissed the case on jurisdictional grounds, holding that "the public

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is not covered by Medicaid . . . it is not under the subject matter jurisdiction of a SCDHHS Hearing Officer.” By Order dated May 12, 2009, this Court affirmed. *Peter Brown v. DHHS*, 2009 WL 1744572 (S.C. A.L.C. 2009). This Court denied rehearing on June 18, 2009.¹

The Court of Appeals reversed in an opinion dated April 20, 2011, holding that the legal conclusions on which the decision of this Court was based were not considerations that affected subject matter jurisdiction. *Brown v. South Carolina Dept. of Health and Human Services*, 393 S.C. 11, 18, 709 S.E.2d 701, 704 - 705 (Ct. App. 2011). The Court of Appeals accordingly remanded the case for a hearing on the merits. *Id.* at 705.

On remand, DHHS advised the Hearing Officer by letter dated February 26, 2013, that “After balancing the costs versus the benefits of litigating this matter further, DHHS has decided not to contest the above-referenced case on the merits. Therefore, DHHS does not believe that a hearing is necessary in this matter.” Appellant’s counsel, who was copied with this letter, did not respond to that letter.

In its prehearing brief, DHHS reiterated the position stated in its February 26, 2013 letter that based on cost to the agency, DHHS would no longer contest the merits of the case; that is, the Appellant’s entitlement to one-on-one services.

On March 7, 2013, Appellant’s counsel filed a one-page, two-paragraph Pretrial Brief. It was not responsive to the position of DHHS as announced in the February 26, 2013 letter. That Pretrial Brief did not acknowledge or otherwise note that DHHS was no longer contesting Appellant’s entitlement to the services at issue. Instead, the document stated “that the agency has erred by basing its decision to terminate Appellant’s one-on-one or companion services on erroneous grounds. . . .”, even though the agency had given notice that it was changing its

¹ On p. 4 of the Brief of Appellant, it is erroneously stated that the denial of rehearing occurred on October 1, 2010, but that was the date on which this Court denied a petition for supersedeas.

decision to terminate services. Appellant's Pretrial Brief also asserted that the agency "has failed to provide medically necessary services," but offered no indication regarding what services had not been provided.

On March 11, 2013, the Hearing Officer advised the parties that based on the pretrial briefs the case was moot; that the hearing scheduled for March 13, 2013, was canceled; and that an order would be forthcoming within a week. Appellant's counsel did not express an objection to the cancellation of the hearing.

By order dated March 12, 2013 (mailed March 19, 2013) the Hearing Officer dismissed this appeal as moot, holding as follows:

The issues of remand as set forth in [the Court of Appeals' opinion], whether or not the "one-on-one" service is a Medicaid service and whether or not the Petitioner needs such services in addition to RHS, are moot based on Respondent's decision not to contest the case on the merits and agrees that the Petitioner as an ID/RD Waiver participant will be allowed to receive ACS offered by the ID/RD Waiver, provided by the qualified provider of his choice, in the same amount, duration, and scope as the Petitioner received "one-on-one" services at the time of Petitioner's appeal in 2005.

Appellant's representatives filed the present appeal, but did not challenge the Hearing Officer's conclusion concerning mootness.²

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

² Respondent has provided information to the Court concerning a federal case in which Appellant's representatives have sought, on other grounds, the relief sought in the present case. This information is not reiterated in this Order, because it is not necessary to the decision of the issues in this appeal.

of the APA, specifically, Section 1-23-380(5), 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(5) (Supp. 2012).

CONCLUSIONS OF LAW

- 1. Appellant has received all the relief he requested, and therefore is not entitled to additional relief.**

Appellant's counsel stated at the outset of this matter in 2005 that "the only issue currently on appeal before the Division of Appeals and Hearings, is the agency's proposed reduction of twelve hours of services which are needed weekly. . . ." That sole issue has been resolved in Appellant's favor as a result of the DHHS decision not to contest his entitlement to the twelve weekly hours of services.

The relief actually sought by Appellant is not entirely clear. It appears, however, that the only relief Appellant now seeks under that argument heading is an order granting a hearing, based on an unsupported claim that "as of June 14, 2013," the services ordered in the March 12, 2013, Order, were not being provided. In other words, Appellant's current complaint is addressed to alleged noncompliance with the March 12, 2013, Order at a time several months after its issuance.

Appellant also appears to request, without any factual showing other than the argument of counsel, that this Court “schedule a hearing to take evidence of the irregularities in this process. . .” *Id.* This is an apparent reference to § 1-23-380(4), which provides as follows:

The review must be conducted by the court and must be confined to the record. In cases of alleged irregularities in procedure before the agency, not shown in the record, and established by proof satisfactory to the court, the case may be remanded to the agency for action as the court considers appropriate.

(Emphasis added.)

The Record does not contain evidence of these alleged “irregularities.” The statute requires a showing of irregularities “by proof satisfactory to the court,” but Appellant’s counsel has offered no evidence of whatever is being claimed.

Appellant cites several procedural requirements found in federal regulations, but offers no suggestion as to how he was prejudiced by the alleged failure to comply with those regulations. A hearing was not necessary in order for the Hearing Officer to decide that the case was moot, which was a decision in favor of Appellant. Again, Appellant’s counsel stated at the outset of this process in 2005 that “the only issue currently on appeal before the Division of Appeals and Hearings, is the agency’s proposed reduction of twelve hours of services which are needed weekly. . . .” Once DHHS decided not to contest Appellant’s challenge to that reduction, the sole issue was resolved in Appellant’s favor, leaving nothing else to be heard or decided by the Hearing Officer.

To the extent that Appellant now argues that a hearing should have been held in order to review claims that the services already being provided were inadequate, Appellant never raised that claim before the Hearing Officer, even after DHHS requested that the hearing be canceled on the basis of mootness, and after the Hearing Officer had provided advance notice that the hearing would be canceled and that case would be dismissed as moot. Appellant’s Prehearing

Brief contained nothing which would suggest that Appellant's representatives wished to present evidence on the nature of the services that Appellant was then receiving. To the contrary, the one-page Pretrial Brief did not raise the issue with any specificity, and therefore cannot be claimed to have brought the issue to the attention of the Hearing Officer. *See, e.g., South Carolina Dept. of Transp. v. First Carolina Corp. of S.C.*, 372 S.C. 295, 302, 641 S.E.2d 903, 907 (2007)(in order to be preserved for review, an issue must be "raised to the trial court with sufficient specificity," citing Jean Hoefer Toal et al., *Appellate Practice in South Carolina* 57 (2d ed. 2002)); *Wilder Corp. v. Wilke*, 330 S.C. 71, 76, 497 S.E.2d 731, 733 (1998)("an objection must be sufficiently specific to inform the trial court of the point being urged by the objector"). As a result, the issue therefore may not be presented in this appeal. *See, e.g., Carson v. South Carolina Dep't of Natural Res.*, 371 S.C. 114, 120, 638 S.E.2d 45, 48 (2002)(court sitting in appellate capacity may not consider issues not raised or ruled on by administrative agency). *See also*, ALC Rule 36(G)("The Administrative Law Judge will not consider any fact which does not appear in the Record").

Appellant cites and discusses *Catanzano v. Wing*, 103 F.3d 223, 227 (2d Cir. 1996), claiming that in the present case (as apparently occurred in *Catanzano*), "the State's agent [Charles Lea Center] refused to provide the services that had been ordered. . . ." Again, however, Appellant's representatives did not present this issue to the DHHS Hearing Officer. Based on the same authorities cited above, the issue is not properly before the Court in this appeal.

2. Appellant seeks an advisory opinion about matters that were neither raised to, nor ruled on, by the Hearing Officer.

Appellant's second question asks this Court to act in a manner completely contrary to principles of appellate practice. Apparently, Appellant would like for this Court to issue an order

as to what this Court is not deciding. Appellant is therefore seeking an advisory opinion from this Court.³

The issue is not only advisory, but also concerns an issue that, like Appellant's first question, was never presented to or ruled upon by the Hearing Officer. This is reason enough for this Court to decline to consider it. *Carson v. South Carolina Dep't of Natural Res.*, *supra*.

This issue also does not seek reversal of anything in the March 12, 2013 Order of the Hearing Officer. In the absence of such a request for reversal, Appellant is not seeking anything that may properly be sought from a court sitting in an appellate capacity. As the Supreme Court held in *Powers v. City of Aiken*, 255 S.C. 115, 177 S.E.2d 370 (1970),

This is a court of review. The purpose of an appeal under our procedure is to determine if the lower court did something that it should not have done, or omitted doing something it should have done. A trial judge will not be reversed for failing to grant a motion on a ground that was not submitted to him.

255 S.C. at 117, 177 S.E.2d at 371. Appellant's second question does not seek review of anything, and therefore should not be addressed for that reason as well.

Finally, the relief requested by Appellant's second question is of a purely advisory nature. However, it is axiomatic that such issues cannot be decided. *See, e.g., Booth v. Grissom*, 265 S.C. 190, 192, 217 S.E.2d 223, 224 (1975) ("It is elementary that the courts of this State have no jurisdiction to issue advisory opinions.").

3. Appellant's third question is entirely conclusory, and fails to set forth a basis for reversal.

Appellant's third question is stated in the Brief of Appellants as follows:

³ The issue in Question B is stated on p. 1 of the Brief of Appellant as follows:

"This Court should issue an order affirming that the violations of the Americans with Disabilities Act and § 1983 alleged by Peter in his federal lawsuit are not before this Court and that jurisdiction for those claims lies properly with the federal court."

Respondent has violated the Administrative Procedures Act by enacting binding norms in the administration of the DDSN Medicaid waiver programs, has violated the U.S. Supreme Court's mandate of *Olmstead* to give the greatest of deference to the opinions of Peter's treating physicians in determining the need for services and has retaliated against Peter and his representatives in violation of the Americans with Disabilities Act and Appellant should be allowed to file a supplemental brief after a hearing pursuant to S.C. Code § 1-23-380(A)(5)[sic] in the event that the requested remedial relief is not granted.

Br. of Appellant 1.

ALC Rule 37(B)(1) provides in part that "The statement [of the issues on appeal] shall be concise and direct as to each issue and may be stated in question form. Broad general statements may be disregarded by the Court." Appellant's Question C is neither "concise" nor "direct." Instead, it consists of three or four "broad general statements" combined in a single sentence. As the Supreme Court has held in *Jones v. Lott*, 387 S.C. 339, 346, 692 S.E.2d 900, 903 (2010), and many other cases, "[e]very ground of appeal ought to be so distinctly stated that the reviewing court may at once see the point which it is called upon to decide without having to 'grope in the dark' to ascertain the precise point at issue." To the same effect is *Herron v. Century BMW*, 395 S.C. 461, 466, 719 S.E.2d 640, 642 (2011), which holds (in the context of a Rule 59(e) motion) that "the issue must be sufficiently clear to bring into focus the precise nature of the alleged error so that it can be reasonably understood by the judge."

Appellant offers only a one-paragraph conclusory argument in support of this point, and it bears little or no resemblance to the argument heading. In fact, the argument of the point is not much longer than the statement of the issue. Appellant argues, in summary fashion and without any details, that he "has been prejudiced in bringing these [unstated] issues to the attention of this Court because of the eight year lapse of time without providing the hearing ordered by the Court of Appeals and required by the Medicaid Act." This contention fails "to bring into focus

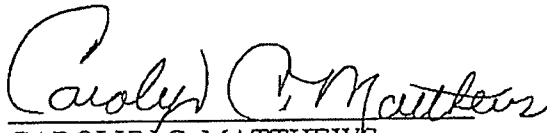
the precise nature of the alleged error. . . ." *Herron, supra*. It does not challenge any issue that was actually brought to the attention of the Hearing Officer or decided by the Hearing Officer.

The conclusory argument of this vaguely-stated issue sheds no light on the nature of the error asserted. The appellate courts of this State have often held that such conclusory arguments will not be considered. *See, e.g., Muir v. C.R. Bard, Inc.*, 336 S.C. 266, 298, 519 S.E.2d 583, 600 (Ct.App.1999)(declaring that conclusory arguments may be treated as abandoned); *Englert, Inc. v. Netherlands Ins. Co.*, 315 S.C. 300, 304 n. 2, 433 S.E.2d 871, 873 n. 2 (Ct.App.1993)(stating that a one sentence argument is too conclusory to present any issue on appeal). This is especially true in this case, when Appellant simply asserts "prejudice" without showing how he was prejudiced, or what specifically is requested. *See, e.g., State v. Colf*, 332 S.C. 313, 322, 504 S.E.2d 360, 364 (Ct. App. 1998)(holding an appellant's argument meritless where appellant did not argue or show prejudice except in conclusory fashion). For the reasons stated in the above authorities, the Court declines to consider this issue.

CONCLUSION

For the foregoing reasons, the Order of the DHHS Hearing Officer dismissing the matter as moot is affirmed.

AND IT IS SO ORDERED.


CAROLYN C. MATTHEWS
Administrative Law Judge

February 4, 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 2 copy herof, in the United States mail, postage paid, or in the Interagency Mail Service addressed to the party(ies) or their attorney(s).

This 4th day of February 2014
By: Mary Beth Campbell
Judicial Law Clerk

PLEADINGS

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF SOUTH CAROLINA GREENVILLE DIVISION

Peter B., Jimmy "Chip" E. and
Michelle M.,

Plaintiff,

vs.

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.

) Civil Action No. 6:10-767-JMC-BHH

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) REPORT AND RECOMMENDATION

OF MAGISTRATE JUDGE

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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. 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. Corraling 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.

<u>Service</u>	<u>Before 1/1/2010</u>	<u>After 1/1/2010 (proposed/actual)</u>
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.

<u>Service</u>	<u>Before 1/1/2010</u>	<u>After 1/1/2010 (proposed/actual)</u>
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 Lacy 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

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

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/MedicaidStWaivProgDemoPG1/05_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.

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 irreparable 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

with which the undersigned has wrestled. Whatever want of quality in the plaintiffs' claims as to the first two elements of their request for preliminary injunction is aided, here, where the balance of harms fails to raise any sort of alarm in the defendants' favor. The plaintiffs lead difficult lives, and the Court would tend to take seriously any evidence which threatens the stability and viability of them, particularly where maintaining the current benefit levels so negligibly impacts the defendants. The injunction may never be transformed into a permanent one, but in the interim, it is a small cost to provide temporary relief. The Court does not mean to undercut the ultimate strength of its recommendation. In all respects, the undersigned believes that an ongoing violation of the ADA is present.

Public Interest

Finally, the public interest clearly weighs in favor of an injunction in this case. First, the public has an interest in the application of the ADA and its particular legislative mandates and purposes. See e.g. *Fisher*, 335 F.3d at 1180; *Heather K. v. Mallard*, 887 F.Supp. 1249, 1263-66 (N.D. Iowa 1995). Second, the information presently before the Court suggests that the plaintiffs request will actually cost taxpayers less money than the alternative care proposed by the defendants, which is obviously a matter of public concern. Again, these interests are not assailed by the defendants.

Accordingly, insofar as the plaintiffs have made sufficient showing concerning each element of their request for preliminary injunction, the Court would recommend that it lie.

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

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

Peter B., Jimmy “Chip” E., and
Michelle M.,

Plaintiffs,

v.

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.

ORDER AND OPINION

C.A. No.: 6:10-cv-00767-JMC

Plaintiffs Peter B., Jimmy “Chip” E., and Michelle M. (“Plaintiffs”) bring this action against Defendants Marshall C. Sanford, Emma Forkner, Beverly Buscemi, Kelly Floyd, The South Carolina Department of Health and Human Services (“DHHS”) and The South Carolina Department of Disabilities and Special Needs, 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 Magistrate Judge’s Report and Recommendation [Doc. 71] recommending that Plaintiffs’ Motion for Preliminary Injunction [Doc. 12] be granted. After a thorough review of the record in this matter, the applicable law, the Magistrate Judge’s Report and Recommendation, and Defendants’ objections, the court adopts the Magistrate Judge’s Report and Recommendation for the reasons stated below.

STANDARD OF REVIEW

The Magistrate Judge makes only a recommendation to this court. The recommendation has no presumptive weight. The responsibility to make a final determination remains with this court. *See Mathews v. Weber*, 423 U.S. 261, 270-71 (1976). The court is charged with making a *de novo* determination of those portions of the Report and Recommendation to which specific objection is made, and the court may accept, reject, or modify, in whole or in part, the recommendation of the Magistrate Judge or recommit the matter with instructions. 28 U.S.C. § 636(b)(1).

FACTUAL AND PROCEDURAL BACKGROUND

The Report and Recommendation sets forth in detail the relevant facts and procedural background of this matter, and the court incorporates by reference the Magistrate Judge's recitation [Doc. 71, at 2-7].¹

DISCUSSION

I. Justiciability

Defendants contend that the Magistrate Judge erred in finding this case ripe for adjudication. Specifically, Defendants contend that Chip and Michelle do not present the court with a justiciable controversy because they have not actually been subject to the proposed reduction in services due

¹Defendants note that the Magistrate Judge inaccurately described the concept of "waiver." In describing the operation of the waiver, the Magistrate Judge attributed the decision to exercise a waiver to certain qualifying individuals. By way of clarification, the actual waiver is an act of the Federal DHHS Secretary. Once the waiver is put in place, qualifying individuals may exercise certain service options including the option to participate in the provision of services outside the institutional setting.

Defendants also take issue with the Magistrate Judge's estimation of hours provided to Chip and Michelle for personal care and respite services before and after the service changes at issue in this case. The court understands that the exact computation of relevant service hours is a point of dispute between the parties. However, for purposes of this motion, the exact calculation is unnecessary as there is no dispute that the changes effected by the January 1st Amendment ("Amendment") alters the allocation of the type of services provided prior to the Amendment, even if the total number of service hours provided changes slightly or not at all as Defendants contend.

to Defendants' promise to maintain pre-Amendment service levels during the pendency of the State appeals process.

The federal court has jurisdiction over an action only where a justiciable "case or controversy" exists. To satisfy the requirements of Article III, a plaintiff "must allege some threatened or actual injury ..." *Linda R.S. v. Richard D.*, 410 U.S. 614, 617 (1973). The alleged injury must be sufficiently real and not merely conjectural or hypothetical. *Blum v. Yaretsky*, 457 U.S. 991, 1000 (1982) (quoting *O'Shea v. Littleton*, 414 U.S. 488, 494-96 (1974)). The requirement that the harm alleged be of sufficient immediacy does not, however, require plaintiffs "to await the consummation of threatened injury to obtain preventive relief." *Id.* (citations omitted).

In this case, the proposed changes under the Amendment in the case of Chip and Michelle and the actual changes imposed on Peter B. represent a modification of services that could substantially impact each of their abilities to remain in the community. While the court recognizes that Chip and Michelle's services have been temporarily stayed at the discretion of Defendants, their ability to seek redress and more stable resolution through the court remains independent of the vagaries of Defendants. The evidence in the record, as thoroughly recited by the Magistrate Judge, demonstrates that the threat of institutionalization is very real and Plaintiffs' claims are ripe for adjudication now. *See Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1181 (10th Cir. 2003) (findings that an individual need not be institutionalized before he could challenge a discriminatory law or policy under the ADA).

II. Injunctive Relief²

Defendants also argue that the Magistrate Judge erroneously recommended that a preliminary injunction issue because there is no likelihood of irreparable injury and it is unlikely that Plaintiffs will prevail on the merits.

“A preliminary injunction is an ‘extraordinary remed[y] involving the exercise of very far-reaching power to be granted only sparingly and in limited circumstances.’” *MicroStrategy, Inc. v. Motorola, Inc.*, 245 F.3d 335, 339 (4th Cir. 2001); *see also Real Truth About Obama, Inc. v. Fed. Election Comm’n*, 575 F.3d 342, 345 (4th Cir. 2009), *vacated by* 103 S. Ct. 2371 (April 26, 2010), *reinstated in relevant part by* 607 F.3d 355 (4th Cir. June 8, 2010). Generally, the goal of a preliminary injunction is to “protect the status quo and to prevent irreparable harm during the pendency of a lawsuit, ultimately to preserve the court’s ability to render a meaningful judgment on the merits.” *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d 517, 525 (4th Cir. 2003).

To determine whether a plaintiff is entitled to a preliminary injunction, the plaintiff must demonstrate “(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.” *Winter v. Natural Resources Defense Council, Inc.*, 129 S. Ct. 365, 374 (2008). “[A]ll four requirements must be satisfied.” *Real Truth About Obama, Inc.*, 575 F.3d at 346; *see also Winter*, 129 S. Ct. at 376.

First, Defendants contend that it is very unlikely that the reduction in services to Plaintiffs will result in institutionalization; and, therefore, there is no likelihood of irreparable injury. More particularly, Defendants claim that the Magistrate Judge’s recommendation was based on

²Defendants ask the court to defer to the State court actions in the Administrative Law Court and the appellate court related to Peter. The State court actions do not relate to Plaintiffs’ ADA claims. Additionally, the State court dispositions thus far have not evaluated the merits of injunctive relief, but rather relied on State court procedural law.

conclusions of the possible effects of institutionalization instead of the actual possibility that Plaintiffs may be placed in an institution based on the reduction in services.

Plaintiffs seeking injunctive relief must demonstrate that irreparable harm is likely in the absence of an injunction, not merely speculative. *Winter*, 129 S. Ct. at 376. Plaintiffs seeking injunctive relief must do more than establish the “‘possibility’ of irreparable harm.” *Id.* at 375. Instead, the “frequently reiterated standard requires plaintiffs seeking preliminary relief to demonstrate injury is *likely* in the absence of an injunction.” *Id.* (emphasis supplied) (citing *Los Angeles v. Lyons*, 461 U.S. 95, 103 (1983)); see also *Real Truth About Obama, Inc.*, 575 F.3d at 346-48 (holding that the preliminary injunction standard articulated in *Winter* has overruled the Fourth Circuit’s previous standard for preliminary injunctions found in *Blackwelder Furniture Co. v. Selig Mfg. Co.*, 550 F.2d 189 (4th Cir. 1977)). The harm to be prevented must be of an immediate nature and not simply a remote possibility. *In re Microsoft Antitrust Litig.*, 333 F.3d at 527.

Plaintiffs submitted reliable evidence in the form of affidavits from their treating physicians and testimony of their current caregivers that supported their allegation that a reduction in services would cause dramatic changes in their current living conditions. Based on the physicians and caregivers’ knowledge of Plaintiffs’ needs, they attested that service reductions would lead to the need for institutional care. The Magistrate Judge noted these affidavits in her report in addition to detailing the possible consequences of placing Plaintiffs in an institution. 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 Defendants’ position to wait until the effects of the service reductions are certain.

Next, Defendants argue that the Magistrate Judge erred in finding a likelihood of success on the merits. Because a preliminary injunction grants relief on a temporary basis prior to trial, the party seeking the preliminary injunction must demonstrate that it is likely to succeed on the merits at trial by “a clear showing” and may not rest on merely the probability of success. *Real Truth About Obama, Inc.*, 575 F.3d at 345 (citing *Winter*, 129 S. Ct. at 376). The ADA prohibits states from discriminating against mentally disabled persons through unnecessary segregation. *Olmstead v. L.C.*, 527 U.S. 581, 600-02 (1999). Under the ADA, states are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, 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 587.

In this case, the only dispute between the parties’ concerns whether Defendants can reasonably accommodate Plaintiffs’ community placement given the resources available to the State and the needs of others with mental disabilities. Plaintiffs submitted substantial evidence tending to show that the State has available resources to maintain the services required for Plaintiffs to remain in community placements. Plaintiffs have further submitted evidence that demonstrates the possibility that community placement will result in net savings to the State for the services required for Plaintiffs. The Magistrate Judge’s report outlines this evidence in detail.

Based on the evidence in the record at this point in the litigation, Plaintiffs have a sufficient likelihood of success on the merits to support the imposition of a preliminary injunction.

Finally, Defendants urge the court to find that preliminary injunctive relief would cause harm to Defendants and to the public interest. In determining whether to allow injunctive relief, the court “must balance the competing claims of injury and must consider the effect on each party [and the public interest] of the granting or withholding of the requested relief.” *Winter*, 129 S. Ct. at 376

(quoting *Amoco Prod. Co. v. Gambell*, 480 U.S. 531, 542 (1987)). However, Defendants provide the court with little argument regarding the possible harm they will suffer should the injunction be allowed. Defendants essentially claim that injunctive relief would undo the Amendment. Defendants ignore the fact that the very purpose of injunctive relief is to maintain the status quo while the merits of the case are litigated. If the court accepted Defendants' assertion of harm, the preliminary injunctive relief would never be appropriate. On the other hand, absent the requested relief, Plaintiffs are subject to a reduction in services at any time - despite the ongoing litigation over the legitimacy of the reduction. The possible harm to Plaintiffs in this case outweighs the possible harm to Defendants and the public interest will not suffer from temporarily requiring the State to do that which they claim they would voluntarily do anyway pending the resolution of this matter.

For the foregoing reasons, the court adopts the Magistrate Judge's Report and Recommendation [Doc. 71] and **GRANTS** Plaintiffs' Motion for Preliminary Injunction [Doc. 12]. Defendants shall maintain and/or return services in the quality, kind, and volume enjoyed by Plaintiffs prior to January 1, 2010, and, in the case of Peter B., prior to July 2009.

IT IS SO ORDERED.

s/ J. Michelle Childs
United States District Judge

March 7, 2011
Greenville, South Carolina

STATE OF SOUTH CAROLINA

)

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DECLARATION OF CAROLYN B. BROWN

COUNTY OF RICHLAND

)

Now comes Carolyn B. Brown, mother of Peter Brown, who states and affirms:

1. I am the mother of Peter B., who has mental retardation, hydrocephalus, diabetes, coronary heart disease, an anxiety disorder and depression.
2. For the first time since he was diagnosed with diabetes, Peter's blood sugar has not been controlled by diet, exercise and two diabetes medication, and his physician had to order a third diabetes medication and I believe that this deterioration in his condition is directly attributable to his not getting the exercise when he was receiving 12 hours a week of companion services prior to July 2009.
3. The deterioration in Peter's condition has been scientifically documented by his sugar levels not being controlled by ^{SA} ~~Gulcophage~~ ^{Glucophage}, exercise and diet. This is the first time since he was diagnosed that Peter's sugar levels have been uncontrolled.
4. Peter's uncle died prematurely of problems caused by diabetes.
5. Previously, his companion would take him on activities where he would get aerobic exercise on the weekends, but now the only weekend activity for Peter is to attend a congregate day program with other disabled persons, or hang around his apartment complex.
6. Peter has become more withdrawn and he feels like he has done something wrong to have his companion services terminate.
7. Peter will not initiate exercise without having someone participate with him and he has no conception of the effects lack of exercise will have on his health.
8. It is imperative that Peter eat meals as scheduled, but he has gone for hours past his scheduled meals due to staff having other duties or just not paying attention to his diabetic condition.
9. The "regular" staff members at Peter's program have little understanding of the medical implications of diabetes and the Defendants have ignored my repeated requests to get training for them.
10. For the past two years, Peter's physician-approved plan of care required an evaluation by a dietician and that staff follow his physician approved diet, but the Defendants have utterly ignored this plan of care.
11. Since Judge Childs ordered Peter's companion services to be restored, there has now been

a hodge podge of at least eighteen different staff members sent into his apartment to be his "companion," whereas, before he had one companion spending 12 hours a week with him with no other obligations during those twelve hours but to focus on Peter's needs. As a direct result, staff has enabled him to consume products that have increased mounts of sugar and this has confused him in following his physician order dietician prepared diet.

12. Most of these employees have no training in diabetes management and they are frequently distracted by their other duties taking care of other clients.
13. Before 2009, Peter had a single companion who had no other duties during Peter's assigned "one-on-one" or companion time than to spent twelve hours with Peter.
14. Some of the staff members who are assigned to Peter are hostile to him and to me, because they have other duties and have been informed by Charles Lea Center management that Peter does not need these services, but they have absolutely no recognition or understanding of the devastating effects of diabetes if his diet is not followed and he does not get regular exercise, as required by the American Diabetes Association guidelines.
15. Peter's work schedule has been reduced to where he only works two days a week, further limiting his interactions with non-disabled persons since Defendants claimed to have "restored" his services. Now, Peter just hangs around his apartment most of the time when he was previously at work.
16. Peter is no longer able to push around heavy carts at work and his stamina is greatly decreased.
17. Staff has not administered Peter's medication on the schedule ordered by his physician.
18. When long time friends and team members in Columbia have seen Peter in the past year, they comment about the noticeable deterioration in his condition.
19. DDSN continues to bill Medicaid more than double the cost of the services Peter now receives.
20. DDSN continued to bill Medicaid for service coordination (targeted case management) services after his service coordinator, Jackie Walker, disappeared suddenly. Exhibit 1. Detailed Claims Report for Peter Brown. DDSN pays the Charles Lea Center for targeted case management, although they have not provided this service to Peter in many years. They required Jackie Walker to bill her competitor, the Charles Lea Center, for her services. They paid Charles Lea Center before Jackie Walker disappeared and after she disappeared.

21. Defendants have refused to pay Peter's psychological service provider, Lennie Mullis, since Judge Childs signed the order requiring them to restore services received in 2009, but they have continued to pay the Charles Lea Center. Because it receives a capitated band payment, the Charles Lea Center is supposed to pay for the service of Lennie Mullis out of Peter's "band" payment they receive each month, but they have been pocketing the money instead. DDSN has not reduced the amount they pay Charles Lea Center since the Center stopped paying Ms. Mullis.
22. I believe that Defendants have retaliated against Jackie Walker and Lennie Mullis because they were strong advocates for Peter and this has discouraged other persons from advocating for him, because they expect retaliation in return.

I have read this statement and swear and affirm under penalty of perjury that the facts are true, to the best of my knowledge and understanding.

Carolyn B. Brown
Carolyn B. Brown

Sworn to before me this 11th
day of October, 2012.

John K. Brown
Notary Public for South Carolina
My Commission expires: 8-14-2017

STATE OF SOUTH CAROLINA)

COUNTY OF RICHLAND)

DECLARATION OF LENNIE S. MULLIS
DATED FEBRUARY 6, 2012

Now comes Lennie S. Mullis who swears and affirms as follows:

1. I have been providing psychological services to Peter B. [REDACTED] since 2006.
2. I have provided affidavits on behalf of my clients whose services were being improperly terminated by DDSN.
3. In March of 2011, the Charles Lea Center quit paying for the services I provide to Peter B. [REDACTED]
4. I was present at Peter's apartment when Suzan Mason and Michael Floyd came to meet with Peter, who had [REDACTED] but his guardian did not know that they were meeting with [REDACTED]
5. Suzan Mason and Michael Floyd stayed for about twenty minutes.
6. Peter showed Michael Floyd [REDACTED] and he left.
7. After Michael Floyd visited Peter in 2010, he called me trying to get in contact with Peter's guardian.
8. I knew that Peter's guardian did not want him involved or to have contact with Peter and I suggested that he leave a message on her phone.
9. In January 2011, Michael Floyd called me a second time to tell me that I would not be paid unless Peter's guardian agreed to him being the administrator for Peter's MR/RD Medicaid waiver services.
10. Mr. Floyd had one employee a while back, but it is my understanding that the employee left and I am under the impression that now Mr. Floyd is the only service coordinator with his company.
11. Despite there being a federal court order requiring DDSN to continue my services and his physician stating that these services should be continued, Michael Floyd insisted on this call to me that I could not be paid for providing psychological services to Peter unless he authorized them.

12. I send documentation of my sessions with Peter every month to the Charles Lea Center, since I have been unable to obtain a "prior authorization code" to bill DHHS directly for Peter, but since March 2011 Charles Lee Center has not paid me as they did before Judge Childs issued her order.
13. Michael Floyd had previously called me talking about his role being Peter's service coordinator, but I knew that was not true, because his guardian had opted not to use targeted case management.
14. I am not familiar with any other consumer in South Carolina being required to have an "administrator" to receive MR/RD services.
15. I have worked in the DDSN system for twenty-five years and I have never known there to be a requirement to have a "financial administrator."
16. Jackie Walker talked with me at least three times in lengthy conversations about her fear of retaliation by the Charles Lea Center and DDSN before she disappeared.
17. Jackie Walker told me that she had a plan of care that was written, but had not been recorded on the DDSN computer system. The consumer was in compliance, because the meeting had been held and the plan of care developed and documented in writing.
18. At the time, that was a common practice to have plans of care in writing before putting it on the computer and the plan of care was not considered to be out of date because it had not been entered.
19. Jackie Walker told me that she was reviewed by DelMarva, the DDSN Quality Assurance provider, and her rating was satisfactory, but because of this plan of care DDSN again reviewed her and cited her for this plan of care.
20. Jackie Walker felt that the way DDSN responded to this case was retaliatory and she had never heard of this being an issue in the many years she had been a service coordinator.
21. Later, Jackie Walker told me that DDSN had "frozen" her from taking on new cases, but I am not familiar with any provision in the law that would allow DDSN to legitimately "freeze" a provider while allowing him or her to continue to provide waiver services.
22. Jackie Walker had shared information about the Charles Lea Center Workability Center with me and others and she was upset that people who previously worked in the community were being moved to that workshop.



23. Jackie Walker was having tremendous anxiety because she felt that she had been targeted by DDSN.
24. I was present at Peter B.'s plan meeting on the day it was confirmed that Jackie Walker would no longer provide his service coordination services. Although later learned that DDSN and Charles Lea Center knew that Jackie Walker would not be present at this meeting, they did not inform Peter's guardian or me. I traveled two hours to attend this meeting.
25. Armilla Moore instructed other Charles Lea Center employees who were in attendance to leave the meeting.
26. It was extremely uncharacteristic for her not to be present because of her professionalism and her long relationship with Peter.
27. It is common for DSN Board service coordinators to serve as gatekeepers for services and for them to arbitrarily terminate services which have been ordered by consumers' physicians without medical justification.
28. After I provided affidavits in support of Peter and other DDSN consumers, DDSN terminated my certification as a behavior support provider on May 18, 2010, but I have appealed that termination.
29. I work with families and providers across the state and the fear of retaliation by DDSN is common.
30. I do not believe that it would be in Peter's best interest for Michael Floyd to have access to his information or the ability to visit him without approval of his guardian and supervision.
31. I formerly held the position of executive director for a local DSN Board and I am familiar with the administration of the MR/RD Medicaid waiver.
32. For years, the Charles Lea Center has paid my bills for psychological services provided to their consumers and they can determine whether I am providing the services for Peter based on the reports I send to them without Peter having a service coordinator or financial manager.
33. When Jackie Walker was Peter's service coordinator, I sent my bills to Charles Lea Center, not to Jackie Walker.

(Handwritten signature)

I have read this statement and it is true to the best of my knowledge and information.
Further declarant sayeth not.



Lennie S. Mullis

February 6, 2012
Columbia, South Carolina

SWORN TO BEFORE ME
this 6th day of February, 2012.



Nancy C. Law, Notary Public for South Carolina
My Commission Expires: 1-05-2014

STATE OF SOUTH CAROLINA)
) AFFIDAVIT OF LENNIE MULLIS
COUNTY OF RICHLAND)

Now comes Lennie Mullis, who swears and affirms that:

1. I have worked with Peter B. for 5 years, providing psychological supports.
2. I meet with Peter B. approximately twice a month.
3. The calendar which is attached was never shared with me or with the guardian, thus I could not have responded to it before it was received by the guardian and counsel for Peter.
4. I attended Peter's plan of care meeting and this schedule, with services provided by many different staff members, cannot meet the therapeutic goals that were being met by Peter's companion before 2009.
5. The "Accountability for Weekly Hours" provides that the Charles Lea Center provides an "Educational Meal" on Monday from 12:00 to 1:00, but I meet with Peter on Mondays and they have taken him through a drive through window and dropped him off at his apartment to eat his sandwich alone.
6. Supervision shopping for groceries and at the Dollar General is an activity that is provided to all SLP residents and this activity was not included in the 12 hours of companion services Peter received, because providing this service is part of the residential provider's responsibility for all residents.
7. The Charles Lea Center has not implemented the plan of care which was approved by Peter's physician.
8. Sending multiple staff members to provide these services is like sending eleven different substitute teachers to a classroom, instead of having one teacher who knows Peter's needs and understands his therapeutic goals.

FURTHER DEPONENT SAYETH NOT.

Lennie Mullis
Lennie Mullis

SWORN TO BEFORE ME THIS
5th DAY OF AUGUST, 2011.

[Signature]
Notary Public for South Carolina

My Commission Expires: Nov. 19, 2017

AFFIDAVIT OF LENNIE MULLIS

The undersigned appeared telephonically and affirmed the following:

I have provided psychological services to Peter ~~since 2005~~ since 2005.

I meet with Peter at his apartment at least once a month, usually ^{bi-}weekly.

Peter's anxiety has increased since the companion services of Lee Knowles, were terminated in 2009.

I have been concerned about Peter's loss of weight and physical changes, such as loss of hair (in patches) and improperly treated fungal infection on his feet.

Because of his diabetes, it is critically important that the orders of his physician be carried out, but staff frequently provide his 8:00 p.m. medication with his dinner at 5:00 and they have not supervised the ~~washing~~ of his feet as ordered by his podiatrist.

thing and the application of medicine

It is very important, because of his diabetes, that Peter follow the treatment regimen ordered by his doctor to treat his feet, but the staff has not been consistent about following those orders.

Before his services were terminated in 2009, Peter's companion met with him for several hours one night each week to inventory his food cabinet, to prepare his shopping list and to plan activities for the weekend.

"Regular" Charles Lea Center staff took Peter grocery shopping and to Dollar General Store and this was not part of the twelve hours of activities provided by his companion.

Monitoring Peter's meals was not included in the twelve hours of companion services and this is an expected responsibility of the provider of residential habilitation services, not his companion.

Peter does not appear to be consuming the number of calories ordered by his physician.

The trusting relationship Peter developed with his companion, Mr. Knowles, was important in maintaining his psychological health and planning for his weekend activities gave him a sense of control over his life and something to look forward to for the weekend.

Now, on Saturdays, Peter is loaded into a van with other persons who have mental retardation and they are transported to a congregate facility to attend "God's Little Haven" in a large building where Peter is segregated from non-disabled persons.

Some Sundays, Peter has no activity and on other Sundays, he takes a ride with other residents in the van or is taken to the flea market, but the decision as to where to go is usually made by staff.

Mr. Knowles was well trained and he took his job seriously as Peter's companion.

Employees of the Charles Lea Center are fearful of reprisal and they are aware that management wants them to report that Peter does not need companion services.

Peter was devastated when Mr. Knowles' services were terminated and he did not understand what he had done wrong to be punished.

I serve DDSN consumers who live at home and others who live in residential settings in Spartanburg County, but none of them receive companion services from any provider other than the Charles Lea

Center, although there are other providers listed on the DDSN "Qualified Provider List" as providers of Adult Companion Services.

Peter's "one-on-one" staff has responsibilities for other consumers while spending time with Peter and it does not appear that they are giving Peter undivided attention during the twelve hours a week he is supposed to be receiving companion services.

The training provided to Peter by "regular" staff has been inconsistent and this has been detrimental to Peter, who needs consistency and stability to maintain good mental health. *and on social*

Peter does not know from day to day who will be providing his "one-on-one services" and this has increased his insecurity.

I reviewed the assessment performed by Charles Lea Center staff and it overstated his capabilities. For example, it stated that Peter could count change, but he *actually* would not remember to wait for change and would not be able to make change for a dollar.

Peter's October 2010 plan of care contained meaningful and therapeutic goals and objectives which would help him remain as independent as possible.

Since Mr. Knowles' services were terminated in 2009, Peter rarely has been taken on activities where he is not with other disabled persons.

Peter is a "people pleaser" and he is at great risk of being victimized.

Further deponent sayeth not.

Lennie S. Mullis

Lennie S. Mullis

Sworn to me by telephone

on this 11th day of July, 2011.

[Signature]

Notary Public for South Carolina

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA

GREENVILLE DIVISION

CIVIL CASE NO. 6-10-CV-767-RBH-BHH

Peter B., Karen W., Jimmy "Chip" E.,
and Michelle M.,

Plaintiffs,

vs.

Marshall C. Sanford, Emma Forkner,
Beverly Busceml, Kelly Floyd, the South Carolina Department
of Health and Human Services and the South Carolina
Department of Disabilities and Special Needs,
Defendants.

DECLARATION OF LENNIE MULLIS

Now comes Lennie Mullis who swears and affirms:

I am a behavior support specialist and psychological services provider of MR/RD Medicaid waiver services to Peter B. and Michelle M.

I make this declaration based on my personal knowledge of Peter B. and Michelle M. and my experience working with people who have mental retardation for more than 25 years.

Since Peter B.'s companion services were terminated in July 2009, his anxiety level and symptoms of depression have increased significantly.

Peter B. has lost 10 pounds since his companion services were terminated in July 2009.

Peter has been recently exhibiting other signs which appear to me to be symptoms of stress, including inflammation of his skin and loss of hair.

I am concerned that if Peter's regression in his mental state, his social skills and his medical condition continues, he will be unable to continue to work in competitive employment.

Peter takes tremendous pride in his job and his whole sense of self-worth is related to his work. Peter would be devastated if he lost his job at Palmetto Textiles.

Adult companion services are services which are offered through the MR/RD Medical waiver.

The 12 hours a week of companion services Peter received, prior to these services being terminated by SCDDSN and SCDHHS in July 2009, were necessary to maintain his mental and physical well being and to prevent the regression which has occurred since the termination of Peter's companion services.

The Workability Center would be an inappropriate and unnecessarily restrictive placement for Peter because of the lack of stimulation he would receive there and the regression that would occur because of the behaviors of the attendees there. Some of the workshop attendees display physical and verbal aggression.

The social skills of most of the workshop attendees is below Peter's and some of the participants at the workshop exhibit inappropriate social contacts which would be very upsetting to Peter. I would expect Peter's social skills to regress tremendously if he attended the workshop.

Peter would feel isolated and inferior if he were to lose his job and to have to attend the workshop.

Behaviors exhibited by workshop attendees which would be upsetting to Peter include stealing food and invading other persons's personal space.

Before companion services were provided, according to his records and his service coordinator, Peter experienced a dangerous loss of weight. Since his companion services were terminated, he has lost weight rapidly again.

Peter's previous good health condition is deteriorating and this rapid change in his condition is dangerous because of his conditions of diabetes and coronary heart disease.

Peter needs to get exercise, which has been ordered by his physician, to prevent complications from his diabetic condition and his coronary heart disease. Without the encouragement of a companion, Peter will not exercise and he will withdraw into his

apartment.

If Peter's mental health continues to decline, he is at risk of losing his job and having to move to a more restrictive residential setting because of the increase in his anxiety level and the symptoms of depression and the withdrawal he has been exhibiting since his companion services were terminated.

I have provided services to Michelle M. for 4 years which have been funded by the MR/RD Medicaid waiver program.

Michelle is totally dependent upon others for all activities of daily living.

Michelle would be totally unable to defend herself if she were in a facility with persons whose behavior is aggressive.

The workshop or any congregate residential placement would be inappropriate for Michelle at this time and she would regress if she were not able to remain in her home.

Based on my knowledge of Michelle's history, I would expect Michelle's condition to rapidly deteriorate if she were returned to an ICF/MR.

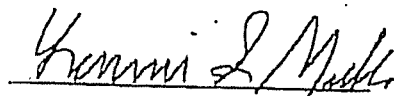
Remaining in her home is the safest placement for Michelle and she risks serious health and medical complications if she were required to return to a Regional Center.

Due to Michelle's medical complications, she would require services in a Regional Center if she were unable to remain at home.

If Michelle were to be moved to a Regional Center, she would require one-on-one supervision because of her tube feeding and the fact that she will try to pull out her gastronomy tube or to stand up while the tube is attached.

It is unsafe for Michelle to walk without hands-on assistance because of her unsteady gait.

I have read this Declaration and I swear and affirm under penalty of perjury, to the best of my knowledge and understanding, that its contents are true.

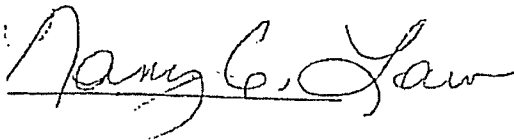


Lennie S. Mullis

I am familiar with the Declarant and I recognize her voice and I do hereby swear and affirm that this Declaration is her statement, as affirmed to me by telephone.

Given to me this 28th day of April,

2010 via telephone.

A handwritten signature in cursive script, reading "Nancy C. Law". The signature is written in dark ink and is positioned above the printed name.

Nancy C. Law

Notary Public for South Carolina

Commission expires 1-05-2014

EXHIBIT 6

2010 Plan of Care prepared by the Charles Lea Center

Plan Date: 1/3/11

Previous Plan Date: 10/21/09

Residential Support Plan

Section I: Personal Information

Name: Peter Brown

Preferred Name:

Social Security Number: 251-08-8857

Medicaid number:

Medicare number:

Address: 577 South Sunflower Way, Moore, SC 29369

Phone Number: 864-921-5550 DOB: 11/2/67 Gender: X Male Female

Name of Primary Contact: Carolyn Brown, Mother
Avenue, # 128 Forest Acres, Columbia, SC 29206

Address: 5225 Clemson

Phone: 803-463-6989

Name of Emergency Contact: Same

Address:

Phone:

Section II: Critical Information

Allergy: No Known Allergies

Reaction:

Response:

Medication precautions: N/A

Behavioral Alerts: (pica, self-abusive behavior, etc). None

Living Will, Advance Directives: ☐ yes X no Location:

Other: Peter is a 42 year old Caucasian male, who functions in the moderate range of mental retardation. He is verbal and ambulatory. He can verbally make his needs and wants known. Peter is assisted by staff to take prescribed medications for diabetes, vitamin supplement, upper respiratory, and high cholesterol. He follows a diabetic diet and menus prepared by a registered dietician. He has a written doctor's order which allows him to sleep late when he is not working. Once Peter is awake, he will call staff to let them know that he is ready to receive his morning medications. Peter is independent in most of his personal care and daily living skills, but requires some monitoring by staff in the areas of housekeeping, laundry, medication administration, and dining. Peter is on a general accountability level, allowing staff to see or speak to Peter by telephone every 3 hours. Although Peter is capable, per his guardian he is not allowed to go anywhere unsupervised, including visiting with the other consumers and walking around the complex; with the exception of visiting the staff at the office. He follows a strict schedule provided by his guardian who calls daily to ensure that he is following the schedule. He is on an independent bathing accountability; which is defined as no supervision required.

Section III: Personal Focus

What do people like and admire about this person? Peter is admired for his friendliness, thoughtfulness of others, and good manners.

What is most important to this person? Peter states that his family, and his job at Palmetto Textiles are most important to him.

What are this person's life goals? Peter states that his goals are to continue to live on his own in his apartment, and to maintain his job security.

How is this person connected to the community? Peter participates in many outings with the other consumers, works, shops, and visits his family out in the community. However, all activities must be approved in advance by his guardian and not at the spare of the moment. As a result, this limits his opportunity to participate in some events, and decreases his opportunity to participate with his peer and nondisabled persons.

Describe relationships that are important to the person: (family, friends, etc): Peter states that the relationships he has with his family, staff, and friends are important to him.

What is currently working well that needs to be continued or enhanced? (Include progress on current training objectives.)

Within the past year, Peter has met criteria in area of community skills. Peter states that he likes to walk, swim, watch television, listen to music, going out to eat, going on outings, and visit with his mother and brother. STL as well as staff allow Peter to make his own choices of where he would like to go and what type of activities he would like to participate in, and then these choices are sent to his guardian for approval. Peter has frequent family contact with his mother, Mrs. Brown through visits and telephone calls. Peter continues to work at Palmetto Textiles during the week; with the exception of Mondays. He states that he is satisfied with all of his CLC services. Peter's guardian was given a choice to allow him to have his own key to his apartment and he desires to have it for the convenience of coming and going as he wishes. His guardian also has a choice of whether Peter attends any meetings concerning him, including HRC meetings. His guardian chose his health care providers and schedules all appointments. The CLC staff may transport Peter to his medical appointments but are not allowed to accompany him during the visit, nor can they discuss his conditions with the healthcare provider. His rights were discussed with him by staff, and Peter states that he understands his rights. However, his rights are limited by his legal guardian who makes all of his decisions. Staff also counseled Peter on abuse, and he states that in the event of an abuse allegation he knows who to contact.

What needs to change? (Include any changes needed in current training objectives.) Peter needs training in the areas of money management, using an alarm clock, setting a watch, reading food labels, and self-administration of medications. It is necessary for Peter to continue to receive care, supervision, and skilled training as he continues to reside in an SLP II apartment.

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Does this person need assistance to adjust water temperature? Yes ☐ No ☒ Comments:

Does this person need assistance to evacuate when a fire or smoke alarm sounds? ☐ Yes ☒ No
Comments:

Does this person need assistance to remain safe around household chemicals? Yes ☒ No
Comments:

Are there any other important or serious safety issues? None noted at this time.

Describe in explicit behavioral terms how staff are to supervise the person during the times below. (Include frequency of supervision checks, method, documentation and frequency of documentation.)

Awake: (specific to location if needed ex. At home, in the community, etc) Staff supervision required every 3 hours. Peter is capable of being in the community alone, but his guardian requires that he has continuous supervision by staff while away from the residence.

Sleeping: No Supervision Required (Peter has a written doctor's order which allows him to sleep late when he is not working.)

Bathing: No Supervision Required

Dining: No Supervision Required; Staff calls to ensure that he is eating the items that are on his menu.

Does this person remain at home without staff support? No ☒ Yes How long? Must be seen or spoken to on the phone every 3 hours

Does this person go away from home without staff support No ☒ Yes How Long? Peter goes to visit his mother in Columbia, SC and also visits his brother in Atlanta on different occasions, and during those visits they are responsible for his accountability. While his mother is visiting with Peter at his apartment she is responsible for his accountability throughout the entire visit.

Is HRC of supervision needed? ☐ Yes Date of last review:

☒ No Explain:

Comments: CLC places no undesired restrictions on Peter's accountability.

Section V: Rights

Does person have a legal guardian? Yes ☒ No

Name and contact information: Carolyn Brown, mother

Comments: No decisions are to be made without contacting Mrs. Brown to get approval. This includes: movement, meals, schedules, interaction with others, healthcare, recreation, shopping, diet, community involvement, etc...

Does person understand their human, constitutional and civil rights? No: ☒ (If no, training must be implemented) Yes: Comments: Peter's rights are limited by court and he has a legal guardian. Peter makes very few choices of his care.

If needed, who will provide assistance in understanding and exercising rights? Mrs. Carolyn Brown and Charles Lea Staff

Are any rights currently restricted? Yes X No

Are restricted rights reviewed/approved by Human Rights Committee? ☐ Yes No X Date of last review:

*Rights are restricted by court.

Section VI: Medical

Health Condition/ Diagnosis	Medication	Dosage	Frequency	Given By	Prescribing Physician
Vitamin Supplement	Cerovite TA		Daily	X staff ☐ Self	Dr. Reel
Diabetes Type II	Metformin ER	500mg	4 tablets Daily	X staff ☐ Self	Dr. Reel
Diabetes	Actos	45mg	Daily	X staff ☐ Self	Dr. Reel
Upper Respiratory Problems	Atrovent	0.03%	2 sprays in each nostril Bid	X staff ☐ Self	Dr. Reel
Hypercholesterol	Zocor	20mg	Daily	X staff ☐ Self	Dr. Reel

Date of last physical exam: 4/26/10

Name of Primary Doctor: Dr Todd Reel

Address: Eastside Family, Suite 1200, Boiling Springs, SC

Phone: 864-591-5900

Pharmacist: Sterling Pharmacy

Address: Columbia, SC

Phone: 803-

Hospital: SRMC

Address: 101 E. Wood St., Spartanburg, SC

Phone: 864-560-6000

Hospitalizations or major illness during past year:

PPD: 5/16/05(0mm)

Dentist: Foothills Dentist

Date of Last dental exam: 6/21/10

Eye care professional: Dr. Roel
Spartanburg, SC

Address: Eastside Eye Clinic, E. Main St.,

Phone: 864-542-1308

Date of last vision exam: 11/09/09

Other Health Professionals: (OT, pt., etc): Dr. Blaakman, Podiatrist, 1604 N. Limestone St., Gaffney, SC (864)487-3338, Dr. Boscia (Lung and Chest) Peter receives counseling services, however no initial or regular documentation has been presented to CLC stating that he is in need of these services.

Diet: ☐ Regular ☒ Restricted (2500 Calorie) ☐ Other Describe: Peter follows a menu prepared by the dietician.

Foods allergies: None noted

Foods he/she does not like: Liver

Adaptive dining devices: N/A

Dietitian: Marilyn Whorton Phone:

Additional Comments Related to Medical: The CLC does not interact with his healthcare provider, and his guardian has informed us of the regularity of his weight through handwritten notes. Although he has reportedly been diagnosed with diabetes, staff does not monitor his diabetic condition in any way. Guardian has reported weight within the past year, but staff has not weighed him. Peter's documented weight is still within his weight range. Peter can indicate if he is ill or injured, but his legal guardian will not allow the staff to administer any over-the-counter medications to him.

Section VII: Adaptive Skills

Communication: ☒ verbal ☐ uses signs ☐ gestures

Hearing: ☒ yes ☐ no Adaptive Devices/schedule of use:

Walk: ☒ yes ☐ no Adaptive device/schedule of use:

Eat: Independently (staff monitors his meals in comparison to his menus)

Bath: Independently

Section VIII: Behavior

Does person display dangerous behavior? Yes ☒ No

If yes, describe:

Behavior Support Plan/Guidelines: yes ☒ no (If yes, attach)

Is BSP restrictive? ☐ Yes ☒ No

Date of consent:

If plan is restrictive, date of most recent Human Rights review and approval:

Section IX: Skills Training

Date and summary of most recent Comprehensive functional assessment: (Include name of tool used and summary of results: Peter's Annual Assessment was completed on 12/20/10. It was determined from his assessment that Peter is independent in most of his personal care and daily living skills. He has assessed needs in the areas of Self-Administration of Meds, Money Management, and Laundry. He will continue to train in the areas of Money Management, Use of Alarm Clock, Self-Administration of Medications, and Personal Safety Skills until criteria is met. Training objectives have been put into place to address these needs.

	Goal	Training Objective	Life Goal to Which It Relates
1	To continue to live independently in an apartment	Peter will record spending of allowance with 90% independence for 3 consecutive months	Money Management Skills
		Staff Person Responsible Direct Care Staff Target Date 11/11	
2	To continue to live independently in an apartment	Peter will read the expiration date on foods products he purchases with 90% independence for 3 consecutive months.	Personal Safety Skills
		Staff Person Responsible Direct Care Staff Target Date 9/11	
3	To continue to live independently in an apartment	Peter will wake up to alarm clock with 90% accuracy for 3 consecutive months.	Waking up in a timely manner

		Person Responsible Direct Care Staff Target Date 10/11	
4	To continue to live independently in an apartment	Peter will correctly identify medications with 90% accuracy for 3 consecutive months.	Self-Administration of Medications
		Person Responsible Direct Care Staff Target Date 12/11	

Comments: (If needs have been identified that you are not training on, explain). Although Peter has assessed needs in the areas of Self-Administration of Meds, Money Management, and Laundry he will continue to train in the areas of Money Management, Use of Alarm Clock, Self-Admin. of Meds., and Personal Safety Skills until criteria is met.

Name: Peter Brown
Date: 1/3/11

Signature Sheet for Plan Meeting

Name	Title

EXHIBIT 4

2010 Plan of Care

**PLAN OF CARE AND RESIDENTIAL SUPPORT PLAN
OF PETER BROWN**

SECTION I. Personal Information

Full Name: Peter Christopher Brown Preferred Name: Peter
Gender: Male Date of Birth: 11/2/67
Height: 5'10' Weight: 154 Race: White Sex: Male
Marital Status: Single Eligibility: MR/RD waiver
Current Address: 577 S. Sunflower Way, Moore, SC 29369
Phone number: 864.921 5550

Emergency contacts are:

	Relationship	Address	Phone
Carolyn Brown	Guardian/mother	5225 Clemson Ave. Columbia, SC 29206	803 463 6989 (c)
Charlie Brown	Brother	2170 Pk.View Ln. NW Atlanta, Georgia	404 643 5493
Patricia Harrison	Advocate	611 Holly St., Cola. SC	803 256 2017 (o) 803 360 5556 (c) 864 836 3572 864 746 6460
Pete Tapp	Team Member		803 787 4683

Emergency contact should be made in the event of any injury or illness, allegation of abuse, neglect or exploitation. In the event of any critical incident, contact should be made immediately. Concerns about a change in condition should be reported immediately.

SECTION II. Critical Information

Peter does not have an advance directive or living will because a legal guardian has been appointed by the Spartanburg County Probate Court. Issues related to any violation of human rights must be discussed with guardian.

No allergies (except seasonal reaction to pollen)

Significant Health, Medical: Hydrocephalus, mental retardation, diabetes, high cholesterol, history of seizures, anxiety, depression.

Care and Supervision: Peter's legal guardian makes all decisions for him.

Impaired Judgment, Behavior: Peter does not always exercise good judgment in making decisions about what he will eat or in matters involving his safety. Peter is too trusting of others. Peter does not assert himself and sometimes allows others to make inappropriate decisions for him.

ASSESSMENTS: This plan of care is based on the assessments of Dr. Reel (treating physician), Lennie Mullis (DDSN psychological services provider) and Marilyn Horton (registered dietitian) which are attached as Exhibits 1, 2 and 3 and team members who have known Peter for many years and have participated in developing his plan of care for years. The functional assessment of a psychologist is attached as Exhibit 4.

SECTION III. Personal Focus

What are this person's life goals? Peter's life goals are to remain involved with his family, to continue working at his job, to be more fully integrated into the community and to spend more time with non-disabled persons and to maintain good health. Peter's life goal includes remaining in the least restrictive appropriate setting, which is in an apartment with appropriate support.

Admired attributes of this person: Peter is a hard worker and is loyal to his employer and his friends. Peter takes great pride in performing a task if he understands the instructions, which must be broken down into simple steps. Peter is honest and trustworthy, but can be easily misled. He makes friends easily, but does not always have good judgment in selecting friends. He respects others. Peter dresses neatly and he accepts criticism. Peter has low self-confidence and may sometimes be too tolerant.

Peter is well behaved and has good inter-personal skills, although he has had little opportunity since his companion services were terminated to be involved with non-disabled persons. Peter

enjoys a variety of opportunities with nondisabled persons. Persons closest to Peter have recognized a decline in his social and verbal skills, a greater inability to articulate his needs and feelings. He has lost a significant amount of weight and is less self-confident. Peter is very sensitive to others.

What is most important to this person?

Peter's family and his job are most important to him. His companion played a very important part in Peter's life. Being able to be involved in the community, with non-disabled persons was very important to him when his companion services were being provided. Peter enjoys attending his home church (Shandon Presbyterian) when visiting with his mother, visiting with his peers and participating in sports, including shooting baskets, driving go karts, bowling, hiking and swimming.

Relationships that are important?

Peter's relationships with his family, his peers and people who work with him are important. Peter benefitted from relationships with non-disabled persons when he was receiving companion services.

What is going well that should continue?

Working outside of a sheltered workshop should continue. Peter should continue to live in an apartment setting, but he will need additional supports to avoid regression and further deterioration in his condition.

What is not working well that needs to change?

Peter thrives in a structured setting with encouragement and support. Peter has not received the training and support he needs to comply with his diet and has not received exercise ordered by his physician. He has lost a significant amount of weight and does not receive adequate exercise to prevent complications from diabetes. Since Peter's companion services were terminated, his psychological services provider has reported signs of increased anxiety and depression. Peter's 12 hours a week of companion services need to be restored to avoid further deterioration.

SECTION IV: Safety/Supervision

SUPERVISION:	Type	Method	Frequency of Documentation in Supervision Log

1. When awake	See below	Visual	3 hours

Peter may be left unsupervised during waking hours in his apartment and at work or other activities which have been approved in advance by his guardian. He should be contacted during waking hours either by phone or visually every three hours by staff when he is in his apartment. Peter should not be left unsupervised in public places. However, he may be left for up to one hour in Publix to shop with his completed grocery list with staff remaining on site (in parking lot or store).

2. When eating	Every meal	Visual	Each meal

Peter's physician has determined that he should be monitored visually by staff at every meal to assure that he complies with physician ordered diet of a minimum of 2500 calories and to insure that he consumes the food prepared. Lunch prepared to be eaten at the job site or on weekend/holiday outings should be checked visually by staff before Peter leaves his apartment to assure compliance with diet and to assure that snack is packed and this should be documented in his menu book. At breakfast, staff should document in his menu book that they have inspected his meal and that he has consumed food on breakfast menu. At dinner, staff should document in menu book that meal meets dietary requirements and that food is consumed. When staff administers 8:00 p.m. medication, staff should document in menu book that snack is eaten. Documentation should include the date, staff's initial and time of day.

When bathing: Peter may bathe independently.

When sleeping: None

Care: Peter controls bladder and bowel

Peter eats by himself but requires visual supervision from staff at each meal (except when at work) to assure calorie intake and dietary guidelines above.

Peter bathes by himself.

Peter walks by himself but has unsteady gait.

Peter dresses himself

Peter is able to communicate

Peter is able to see, but he has a cataract. His eye to hand coordination is impaired. Staff should be vigilant in reporting changes in eye sight to the guardian due to risk of complications from diabetes and he requires regular check ups.

Peter is able to hear

Peter is able to adjust water temperature

Peter is not able to administer medication per his physician and he requires visual supervision for administration of all medication, as ordered by physician. Administration of medication must be documented on chart in Peter's apartment with the date, name of staff administering the medication, name of medication and time medication is administered documented in writing.

Peter needs training on evacuation in the event of disaster.

Risk around chemicals - Peter is safe around common household cleaning agents. He would be unable to assess danger if around chemicals outside of his apartment.

SECTION V: Rights

The Spartanburg County Probate Court appointed a legal guardian for Peter. His guardian understands his human, constitutional and civil rights. Guardian will represent Peter at any review of his rights.

SECTION VI: Medical

Last physical: April 26, 2010 (Dr. Reel)

Last vision exam: September 2009.

Primary Doctor: Dr. Tod Reel

Pharmacy: Blythewood

Medical diagnoses: Treatment

Mental retardation Residential hab. and Peter needs 12 hrs. per week of individualized companion svcs. per Dr. Reel, Dr. Collings and Lennie Mullis.

Diabetes Medication, robust exercise and diet. Needs to maintain a healthy weight. Needs 12 hours per week of companion services to monitor condition, provide exercise and socialization and supervise diet and nutrition per Ms. Whorton and Dr. Reel.

*Medication: Glucophage XR 500 MG (4 tab. w/ p.m. meal)
Actos 45 MG (take in a.m.)*

Rapid weight loss Needs close monitoring and documentation of diet and exercise as set forth in plan of care.

High cholesterol Managed by medication, diet and exercise per plan of care. Needs 12 hrs. wk. companion servcs. to provide exercise and to monitor diet and foods per ordered diet.

Medication: Zocor 20 MG (1 tab. after 8:00 p.m.)

Anxiety Needs psychological services to continue to reduce anxiety.

Depression Needs psychological services to continue to reduce and/or prevent depression.

Allergies: NA. Seasonal reaction to pollen, etc.

Type of Diet: Minimum of 2500 calories a day recommended by registered dietitian and ordered by Physician due to diabetes and high cholesterol. Needs to take multi-vitamin w/ folic acid.

Modified texture: NA

Special Requirements: Needs visual supervision at each meal to assure compliance with diabetic diet and to assure that Peter consumes the number of calories ordered by Dr. Reel and that documentation is complete as required by this plan of care.

Risks: Rapid weight loss, noncompliance with diabetic diet, complications due to diabetes may include problems with vision, kidneys, neuropathy, heart (circulation)

Hospital of choice: Spartanburg Regional

Primary Care Physician: Dr. Tod Reel
1330 Boiling Springs Road, Sptg. 29303 864 591 5900

Pulmonologist: Dr. Boscia

1091 Boiling Springs Road, Sptg. 29303 864 573 6320

Dentist:	Dr. David Bryant 3480 Chesnee Hwy, Chesnee	864 578 9040
Eye Doctor:	Dr. Lawrence Roel 735 E. Main St., Spartanburg, SC	864 542 1308
Podiatrist:	Dr. Hans Blaackman Sptg. Reg. Upstate Podiatry Hwy 290, Duncan S.C.	864
Dermatologist:	Dr. Elizabeth Del Savio 2000 N. Church St., Sptg. 29374	864 582 3448
Neurologist:	Dr. Thomas Collings 324 N. Pine St., Sptg. 29302	864 582 2000
Psychological Svcs.:	Lennie Mullis 1002 Lofty Pine Drive, Cola. SC 29212	864 289 4298
Dietitian:	Marilyn Whorton 108 Hickory Knob Hill Rd., Irmo	

SECTION VII: Adaptive skills.

Communicates verbally.

Hearing is not impaired.

Walks with unsteady gait.

SECTION VIII. Behavior.

Peter does not display any aggressive behavior. Dangerous or self-injurious behavior is likely if proper supervision is not provided because he is unable to recognize danger of non-compliance with diet and he is too trusting of other persons. Peter's team and psychological services provider believe that he does not receive adequate exercise.

Peter will continue to receive psychological services from chosen provider.

Behavior guidelines or support plan: Lennie Mullis will continue to provide psychological

services.

SECTION IX. Skills Training

Functional assessment of psychologist is attached. Assessments of physician, psychological services provider and dietitian are also attached.

Prioritized Goals

Training Objectives

Peter needs to maintain a healthy weight.

The registered dietitian and staff will train Peter in complying with diabetic diet and he will be compliant 95% of the time by consuming a minimum of 2500 calories each day and reaching/maintaining the weight recommended by his physician. Staff will take Peter to be weighed at Dr. Reel's office each month, with weight recorded in (1) Dr. Reel's records, (2) Peter's residential file and (3) Peter's menu book so that he will work toward achieving ideal weight.

This objective relates to goal of living in least restrictive environment in apartment setting and maintaining good health.

Peter needs to comply with diabetic diet.

A trainer will train Peter to inventory his food and supplies and to successfully complete his shopping list each Wednesday or Thursday and will take Peter to shop each Monday with 95% success and will record progress or barriers and the results in writing each week.

This objective relates to goal of living in least restrictive environment in apartment setting and maintaining good health.

Peter needs robust exercise.

Peter will participate in robust exercise in the community away from his apartment complex for at least one hour three days a week (walk briskly in the mall, walk briskly on a trail, swim or other robust exercise at the YMCA, etc.) with non-disabled persons and will be compliant 95% of the time. The person accompanying him will document each exercise session in the record contained in Peter's

menu book and in his residential record. The date, description of the exercise event, time spent exercising and initial of person accompanying Peter will be recorded in his menu book and his residential record.

This objective relates to goal of living in least restrictive environment in apartment setting and maintaining good health.

To function with as much self-determination and independence as possible

Peter will choose and attend a specific cultural or social event in the community with non-disabled persons at least once each week, with the date, description of event and initials of person accompanying him recorded in his residential record and in his menu book

This objective relates to goal of being accepted in the community and living in least restrictive environment in apartment setting.

To function with a clear understanding of rights and safety

Peter will work with his psychological services provider and/or his companion to develop appropriate boundaries and to articulate his emotions in a meaningful way.

This objective relates to goal of living in least restrictive environment in apartment setting.

To receive care, supervision and skills training to live in an apartment

Peter will continue to receive residential habilitation services and training in housekeeping skills. He will receive training each week in measuring dish detergent and washing dishes and in laundering clothes to sort, wash, dry and fold laundry correctly on the new washers/dryers 95% of the time. This training and the results will be documented in writing.

This objective relates to goal of living in least restrictive environment in apartment setting.

To receive care, supervision and skills training to live in an apartment

Peter will comply with the attached daily schedule to provide structure and to comply with doctors' orders related to medication, diet and exercise.

This objective relates to goal of living in least restrictive environment in an apartment setting.

To receive care, supervision and skills training to live in an apartment

Peter will continue to receive residential habilitation services and training in housekeeping skills. He will receive training in mopping floors using swiffer weekly and will work on hand/eye coordination to clean floors thoroughly 95% of the time.

This objective relates to goal of living in least restrictive environment in apartment setting.

To receive care, supervision and skills training to live in an apartment

Staff will train Peter to clean his teeth properly and thoroughly with his electric toothbrush, especially in the back of his mouth 95% of the time to reduce plaque and cavities.

This objective relates to goal of maintaining good health.

To receive care, supervision and skills training to live in an apartment

Due to eye-hand coordination deficits, staff will train Peter to shave his face properly each night and will document progress weekly in his record.

To maintain good health.

Peter will receive regular dental examinations to maintain good dental health Peter will receive dental cleanings every six months and will receive adult dental services as determined to be necessary by his dentist.

To receive routine exams and medical care to maintain health and reduce regression

Peter will receive medical services from Dr. Reel.

This objective relates to goal of maintaining good

health.

To receive regular vision examinations
to maintain vision

Peter will receive an annual vision examination and
vision care as determined to be needed by his
ophthalmologist.

This objective relates to goal of maintaining good
health.

Skills training and objectives under appeal

To comply with diet, maintain weight
and exercise ordered by physician
and to receive social skills training

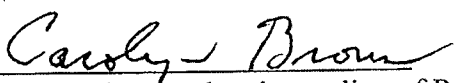
Peter will receive 12 hours a week of companion, or
“one-on-one” services to work on therapeutic goals
and objectives for adult companion services as
described in the attached “Therapeutic Goals and
Objectives of Adult Companion Services for Peter
Brown” and his companion will provide weekly
progress reports in the menu book and in and in
Peter’s Charles Lea Center file.

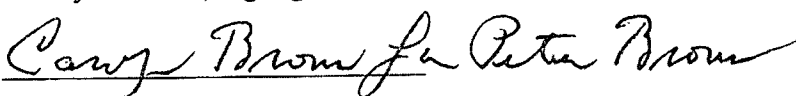
This objective relates to the life goals of living in
the least restrictive setting, maintaining good health
and being integrated into the community.

SECTION X. Financial.

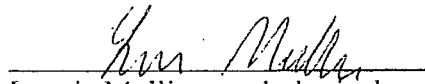
Peter receives regular Medicaid, MR/RD waiver benefits and Social Security Survivor’s benefits. He also earns money at his job. Peter’s physician and the Probate Court have determined that he is not capable of managing his finances. Peter will continue to receive \$1 a day to take to work. The guardian has chosen not to have Peter’s income managed by the Charles Lea Center, but the Center will maintain an activity funds account and his finances will continue to be managed by his legal guardian pursuant to the legal agreement between the Charles Lea Center and the guardian which is attached.

Approval and Signatures of Persons Attending Plan Meeting held on October 22, 2010.

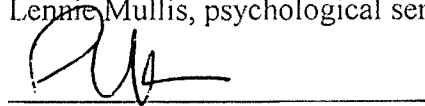

Carolyn Brown, legal guardian of Peter Brown



Peter Brown (signed by Guardian)

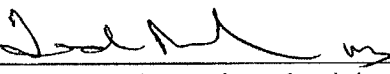
A handwritten signature in cursive script, appearing to read "Lennie Mullis", written over a horizontal line.

Lennie Mullis, psychological services provider

A handwritten signature in cursive script, appearing to read "Patricia L. Harrison", written over a horizontal line.

Patricia L. Harrison, advocate

I am Peter Brown's treating physician and have reviewed this plan of care. This plan of care is medically necessary to provide the care and supervision needed to prevent institutionalization and regression because of Peter's conditions of mental retardation, diabetes and high cholesterol.


Dr. Tod Reel, treating physician

Date: 10-28-2010

I acknowledge that this plan was developed with my input. The priorities, preferences and goals are aligned with supports in this plan. I understand that I may revise this plan at any time and will be allowed to participate in the quarterly review summaries to assess my satisfaction and the effectiveness of this plan.


Carolyn Brown, Guardian for Peter Brown

Copy provided to:

Guardian _____

Service Coordinator _____

Charles Lea Center _____

I did not attend Peter's plan meeting on October 22, 2010, but I have reviewed the plan and, based on my personal knowledge of Peter and his needs, concur with his physician that this plan of care is necessary to allow Peter to function with as much independence and self determination as is possible, given his medical conditions and special needs.

J.F. Tapp Jr
Team member since

Date: BEFORE 1998

Georgine N. Tapp
Team member since

Date: 2006

James K. Wilson
Team member since

Date: 2000

Louise C. Wilson
Team member since

Date: 2000

Marjorie S. Patterson
Team member since

Date: 2000

Mary Beth Siskberg
Team member since

Date: before 1995

Carl P. Cohen
Team member since

Date: 2009

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Exhibit 1. Declaration of Tod Reel, MD dated 22 October 2010

STATE OF SOUTH CAROLINA)
) DECLARATION OF TOD REEL, MD
COUNTY OF SPARTANBURG)

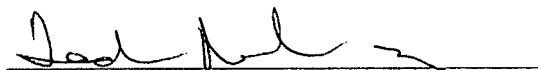
Now comes Tod Reel, who swears and affirms that:

1. I have been Peter Brown's treating physician for nine years.
2. Peter suffers from the condition of diabetes, which is a disease characterized by high blood glucose levels resulting from defects in the body's ability to produce and/or use insulin.
3. Insulin is necessary for the body to be able to use glucose for energy. It takes the sugar from the blood into the cells of the body.
4. When glucose builds up in the blood instead of going into cells, this can lead to complications including heart disease, nerve damage, vision and kidney damage.
5. Risks from uncontrolled diabetes can include amputation and even death.
6. Because of his diabetes, Peter is also at a greater risk for having a heart attack or stroke, which, according to the American Diabetes Association, strike people with diabetes more than twice as often as people without diabetes.
7. Blood vessels carry oxygen and other needed materials to the heart. Coronary artery disease is caused by a narrowing or blocking of the blood vessels that go to the heart.
8. Peter's familial history of premature death from heart disease complicated by diabetes increases his risk of serious and irreversible complications from the disease.
9. A heart attack can occur when the blood supply to the heart is suddenly reduced or cut off. A stroke occurs when blood vessels to a part of the brain are suddenly cut off by fatty deposits or a blood clot.
10. Diabetes can also cause damage to the blood vessels of the eye, potentially leading to blindness.
11. Eye disorders associated with diabetes include retinopathy, which damages the blood vessels in the back of the eye; glaucoma, which causes gradual vision loss from damage to the retina and nerves; and cataracts.

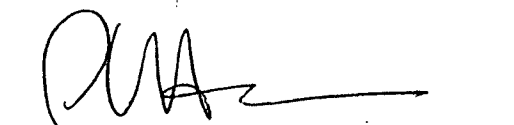
12. Normally, persons who have cataracts do not require surgery until they are in their seventies, but Peter required cataract surgery at the early age of forty-two.
13. Kidney damage is another serious complication of diabetes. The kidneys contain millions of tiny blood vessel clusters that filter waste from the blood. Diabetes can silently and irreversibly damage this delicate filtering system.
14. Damage to the kidneys from diabetes can lead to kidney failure or irreversible end-stage kidney disease, requiring dialysis or a kidney transplant.
15. Kidney disease produces no symptoms until almost all function is gone, as the symptoms of kidney disease are not specific.
16. Diabetic kidney disease can be prevented by controlling blood glucose levels. Controlling blood glucose reduces the risk of progressing to more severe kidney problems by half, according to the American Diabetes Association. Exhibit 1.
17. Diabetes can injure the walls of the tiny blood vessels that nourish the body's nerves, resulting in diabetic neuropathy. About half of all people with diabetes have some form of nerve damage.
18. Meal planning and physical activity are critically important in controlling glucose levels.
19. Because of his intellectual disability, Peter is not able to independently recognize and report indicators of more serious complications of diabetes.
20. Rapid weight loss is a serious indicator of underlying, and often irreversible complications from diabetes.
21. Since Peter's companion services were terminated in July 2009, he has lost 11 pounds.
JMR
22. This rapid weight loss suggests that regular staff at his residential program is not providing the individual supervision that Peter requires to remain in an independent residential placement.
23. Peter's behavior support specialist has documented symptoms of depression and increased anxiety since Peter's companion services were terminated in July 2009.
24. Requiring Peter to attend a large congregate workshop would be expected to further increase his symptoms of depression and anxiety, which would in turn likely result in more rapid deterioration in his physical condition.

25. Based on the deterioration in Peter's physical and mental condition since his companion services were terminated in July 2009, these services should be restored to prevent further damage which may be irreversible.
26. Providing twelve hours a week of companion services to supervise Peter's dietary program and to assure that he receives adequate exercise is reasonable and medically necessary because of his intellectual deficits which prevent him from independently monitoring his condition of diabetes and heart disease.
27. The signs and symptoms Peter has exhibited since July 2009 support the conclusion that regular staff at his facility are not providing the supervision that he requires to maintain his weight, to prevent the regression and the further deterioration in his health condition.
28. If these twelve hours a week of companion services are not restored, Peter's health status is likely to be jeopardized resulting in increased medical costs.
29. The American Diabetes Association is a reliable source of information on diabetes and the attached Exhibit describes some of the complications associated with diabetes.

Executed this 22 day of October, 2010.


Tod Reel, MD

Sworn to before me this 22
day of October, 2010.



Notary Public for South Carolina

My Commission expires: 11-19-2017

Exhibit 2. Statement of Lennie Mullis, Psychological Service Provider

Consumer: Peter Brown

OBJECTIVES: Targeted completion date: 6/11

to decrease symptoms of depression

to decrease symptoms of anxiety

to increase communication skills with others

to decrease feelings of stress

to increase socialization skills

to decrease symptoms of depression

- (1) bi-monthly participation in counseling sessions
 - a. to appropriately express feelings of sadness
 - b. to appropriately express feelings of anger
 - c. to appropriately express feelings of loneliness.

to increase communication and social skills with others:

- (1) participating in regularly scheduled social activities
- (2) participating in bi-weekly exercise programs

to decrease feelings of stress/anxiety

- (1) relaxation training

to increase communication skills

to increase social skills to increase communication with others

- (1) participate in counseling activities, which allow for Peter to make appropriate choices in social settings

- (2) participating in counseling activities that allow Peter to role-play consequences in social settings
- (3) participating in counseling activities that allow Peter the opportunity to state expectations of himself and or others

Summary:

Peter Brown is seen for counseling for the purposes of decreasing anxiety and developing coping skills for stress and anxiety.

During the past year, Peter has had several changes. Effective 7/1/09, Peter's twelve hours of companion services were discontinued. Peter's companion services provided supports with maintaining his diet and providing weekly exercise. Beginning in the fall of 2009, Peter began losing weight. Currently, Peter has lost a total of eleven pounds.

Peter displays signs and symptoms of anxiety. During the past year, there has been no progress in the decreasing of anxiety or depression symptoms, only the maintaining of his skills, and or a decline of the current skills as a result of the increase in symptoms.

Peter tries very hard to please others. Given a situation where Peter would prefer another choice, Peter will do what is asked of him rather than what he prefers.

This past year Peter suffered the loss of his companion, the QLC, and several direct care staff. Peter felt the loss of the staff significantly. Peter has contact with staff daily and he considers them to be his friend and somewhat like a family member. When staff leave, some have reason, some do not, but all in all the once familiar person is no longer there. Many times Peter has verbalized that staff never told him good-bye.

Peter thrives with structure. When the structure changes, there is a period of adjustment, which results in an increase of stress or anxiety. Peter requires and does very well with a schedule. Peter requires monitoring. He needs monitoring with his diet and exercise. I would like to recommend that staff receive training for diabetes to include diet, exercise and medication.

Summary:

Peter is not able to plan or independently implement a program to comply with his dietary or exercise needs, to reduce the severity of his diabetes and heart disease. Due to the fact that Peter is unable to self-initiate physical activity, he needs the weekly companion services for support: to prevent regression of social skills; and to provide the needed supervision of his dietary plan and exercise program. In addition, exercise also reduces stress, which promotes good mental health. Without this companion service, Peter will continue to regress both physically and emotionally, and may require a more restrictive placement.

Consultant feels that Peter requires a minimum of twelve hours of companion services weekly to maintain adequate health, safety and accountability.

RECOMMENDATIONS: Consultant recommends continued bi-monthly counseling for depression and to increase coping skills for depression and anger.



Lennie S. Mullis

WP 9974 Medicaid Waiver Provider

10/18/10

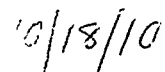


Exhibit 3. Statement of Marilyn Whorton, Registered Dietitian

Approximately 12 years ago, I developed a meal plan to help accurately implement the physician ordered diet for Peter Brown. This basic meal plan is still in place today, however, Peter has been diagnosed with hypercholesterolemia and coronary heart disease in addition to his diabetes. I therefore reviewed Peter's menus and shopping guides and recommended some changes in types of foods purchased in order to better meet his dietary needs.

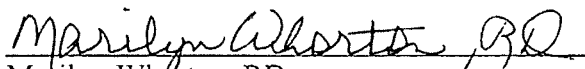
Records indicate that Peter has lost approximately 11 lbs. since companion services were terminated in July 2009. Records also note that Peter exhibits signs/symptoms of depression and increased anxiety since July 2009. It is likely that Peter's weight loss is due either to decreased calorie intake as a result of depression/anxiety, or elevated blood sugars resulting from poor food choices and/or lack of adherence to prescribed meal plan. Either situation can certainly lead to more serious health complications and every effort should be made to help Peter maintain proper weight and nutrition status.

In order to help Peter better understand the importance of his diet, Peter should receive training in general nutrition and, particularly, specific training to learn about how his diet affects his diabetes and cholesterol levels. Training as to how regular exercise can benefit Peter's overall health is also recommended. Training focused on reading labels and recognizing low fat and low sugar foods would allow Peter to make correct food choices and menu substitutions in any situation. Peter's medical diagnoses combined with his history of dangerous weight loss make it extremely important that his diet and exercise plan be closely monitored.

Peter also exhibits the need for continued training in selecting foods in appropriate size packages in order to meet his dietary needs while avoiding excessive waste. Continued monitoring/training in proper cooking methods is also crucial, especially since Peter uses a microwave to cook. It is very easy to overcook foods in a microwave thereby diminishing the foods contribution to Peter's diet.

Peter exhibits many strengths and skills, including being able to grocery shop independently as long as assistance is provided in preparing a weekly shopping list. Because of Peter's significant mental limitations, it is essential that he receive regular reinforcement to prevent regression, to maintain an appropriate weight, and to regulate his diabetes and hypercholesterolemia.

If Peter's diabetic condition worsened so that he became insulin dependent or if he developed more severe heart disease or suffered a stroke, he would require a more restrictive living environment with greater supervision. The complications of poorly controlled diabetes are well documented and include blindness, heart disease, atherosclerosis, kidney disease, and poor blood circulation. The development of any of these conditions could require that Peter be placed in an ICF/MR. Maintaining Peter's current services and closely monitoring his diet and exercise are important in preventing regression and allowing him to remain in a SLP II setting.


Marilyn Whorton, RD

October 19, 2010

Exhibit 4. Psychological Evaluation of Dr. William Baker, Licensed Psychologist

November 8, 2010

To whom it may concern,

This is an evaluation of the adaptive behaviors of Peter Brown, a 43-year-old mentally challenged man. The purpose of the evaluation is to determine whether or not Peter needs care in the form of a companion who spends one-on-one time with him at his home or accompanying him when he makes indicated outings.

The only evaluative instrument used was the Survey Form of the Vineland-II, an adaptive evaluation scale. Describing Peter's behaviors was Ms. Lennie Mullis, who has been Peter's counselor for the last three years. I administered the Vineland.

Let me briefly list my credentials to write this report. I received my Ph.D. from Duke University in psychology. I joined the psychology department of the faculty of Converse College where in the past I served as chairman, and where I am currently employed. I took two years off to complete a Post-Doctoral Program in clinical psychology at USC-Columbia after which I received my license in clinical psychology (South Carolina License #326). I rejoined the Converse faculty and set up a small private practice, which I have maintained for over thirty years.

Equally to the point, I have known Peter for about fifteen years. At that time I ran groups for Charles Lea mentally challenged adults, of which Peter was a member. These groups would identify a problem that one of them had had that week, e.g., loneliness, anger, disagreement with a staff member, and they would talk about how they would deal with it. I had ample opportunity to watch Peter's adaptive skills during these meetings and to form an opinion of his strengths and weaknesses. During this time, I also began to take Peter to lunch at Hardee's on a regular but infrequent basis. Although I have not worked for Charles Lea for at least thirteen years, I have taken Peter to lunch at least twice since then in an effort not to lose track of him.

Let me review a few facts which are well known to everyone, but I believe their review is warranted by their relevance. First, successfully managing diabetes is beyond the skills of many normal adults, even some with superior IQ levels. Most of us know of contemporaries, who are not challenged mentally or emotionally, whose neglect of their diabetic condition has resulted in severe vision impairment, amputation, or death.

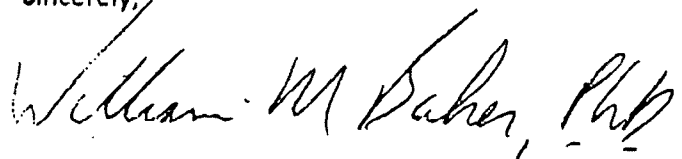
A second fact is that our behaviors are very much under the influence of the behaviors of those with whom we socialize. (This is more true of Peter than of most of us.) A majority of Peter's social contacts are the mentally challenged friends who live in his supervised living program. They will not model the kinds of behaviors which aid in control of diabetes, such as refraining from eating snacks with high sugar content, or exercising for its own sake. In fact, the lack of self-discipline characteristic of mentally challenged adults makes his social environment particularly toxic.

However, reviewing the Vineland to answer the question as to whether or not Peter should be granted a companion is misleading. In an ideal world, not only would every mentally challenged diabetic be granted a companion, but all non-mentally challenged diabetics with insufficient self-discipline would be granted that support as well. Such a program would save eyes, limbs, and lives of normal people. Unfortunately, it is not a resource for normal people, but it is a possible resource for Peter, and it is one which he urgently needs.

Having said that, let me review a few aspects of Peter's Vineland (his full Survey Form is attached.). First, Peter has almost no problem behaviors, e.g., fighting, stealing, etc. He is a model client, which no doubt accounts in part for the fact that he has held a full time job for over twenty years. However, Peter's communication skills are only those of a five to seven year old. His socialization skills are his strength, which are at the level of a junior high school student. His motor skills are those of a kindergartner. With these limitations, it is unreasonable to expect that Peter could tell himself that he needs to exercise and to do so. However, with a companion who would walk with him vigorously a couple of times a week, or who could take him to the YMCA during an appropriate swim time and make sure that he swam, he could reliably tap this resource in his fight against diabetes. Another never ending problem, for the diabetic is not eating taboo foods. A companion could help him plan to purchase appropriate foods, and could monitor that he kept to his plans. A companion could go to the companions with whom Peter most frequently socializes and have Peter explain to them his limitations on food, and encourage them to support his efforts, and follow through on the success of this program. These are only two examples of ways in which a companion could be successful in aiding Peter in his fight against diabetes.

In summary, I strongly urge that Peter be granted the use of a companion without which his diabetes is likely to wreak its havoc. I would also strongly recommend that he continue his bi-weekly counseling sessions with Ms. Mullis.

Sincerely,



William M. Baker, Ph.D.

Licensed Clinical Psychologist

Exhibit 5. Daily Schedule of Peter Brown

Daily Schedule

Peter Brown

On Workdays: Tuesday – Friday

8:00 AM: Wake Up Call, Breakfast, Medication

9:35 AM: Leave for Work, Palmetto Textiles Outlet

4:30 PM: SLP II Staff transports Peter home from Palmetto Textiles Outlet

6:00 PM: Dinner, Medication with Dinner

6:45 PM: Thursday Training Objective: Grocery/Supplies Inventory;
Training Objective: Make Plans for Physical Exercise,
Activities for Saturday, Sunday

8:00 PM: Medication

10:00 PM: Bedtime

On Saturday, Sunday, Monday

Wake Up Call at Peter's Request on Saturday, Sunday, Holidays; Monday – 10:15 AM
Breakfast, Medication (per Dr. Reel's Order)

- I. **On Monday** – Appointments, Grocery/Supply/Other Shopping will be scheduled. Haircuts, other Personal Needs scheduled on Mondays.
- II. **On Monday** – Training Objective: Housekeeping, Laundry
- III. **On Saturday, Sunday** –
 - A. Training Objective: Physical Exercise
 - B. Training Objective: Community Integration
Activities

6:00 PM: Dinner, Medication with Dinner

8:00 PM: Medication

Bedtime at Peter's Choice

Exhibit 6. Therapeutic Goals and objectives of Adult Companion Services for Peter

THERPEUTIC GOALS AND OBJECTIVES OF ADULT COMPANION SERVICES FOR PETER BROWN

October 22, 2010

At Peter Brown's annual Residential Plan meeting on October 22, 2010, Apt. 577, Country Garden Estates; the team discussed his need for the continuation of 12 hours a week of adult companion services. These services are needed to delay or preferably to avoid placement in a more restrictive environment. The team discussed the beneficial results from these services and the fact that Peter is able to live in a setting more independent than most persons with his intellectual and adaptive skills. Peter's physician, his nutritionist, and his counselor submitted statements to document that these services are essential to prevent deterioration in his health, which could be expected with his conditions of diabetes and heart disease (high cholesterol). The following goals and objectives are essential for the following year:

1. His adult companion will discuss with Peter why it is important to limit consumption of foods containing sugar and high fats and will prepare his Weekly Inventory Shopping Lists.
2. Peter's adult companion will consult with his nutritionist to learn how to Train Peter about the role of nutrition and exercise in controlling diabetes and heart disease in order to slow the progression of diabetes and heart disease.
3. Peter and his adult companion will prepare an exercise schedule and Peter will record exercise sessions in his therapeutic log. Peter and his adult companion will review this log weekly.
4. Peter and his adult companion will read content labels on his food and will discuss how healthy eating habits affects diabetes and heart disease and allows him to remain independent.
5. Peter's nutritionist, guardian, adult companion, QLC, and service coordinator will establish and modify specific training objectives for exercise and nutrition as needed.
6. Peter's adult companion will work with his counselor (Lennie Mullis), who will leave written comments of concerns or advice in menu book in Peter's apartment, to develop and enhance social interaction skills to help Peter become more independent and will provide training to teach Peter how to avoid exploitation. Peter will discuss these skills during his outings with his adult companion.

7. Peter with SLP Staff will record his weight in his menu book each month. When he is weighed at Dr. Reel's office, Peter and his adult companion will discuss the importance of maintaining his weight in order to avoid unhealthy weight loss to allow Peter to remain independent and able to live in the least restrictive environment.

The statements of Peter's treating physician, nutritionist, and counselor are attached in support of this Residential Plan.

Presented this 22nd day of October 2010 to be included in Residential Plan.

Carol B Brown

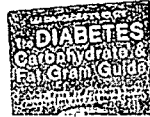
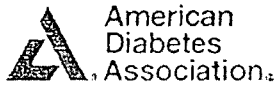
P. W.

Kim S. Mull

Attached are copies of Dr. Reel's Orders for Peter Brown.

Exhibit 1

American Diabetes Association



Search

Find More Books Connect With Others Shop

Diabetes Basics Living With Diabetes Food & Fitness Donate In My Community Advocate News & Research

Donate Today!

Men's Health

Serious Health Implications

Heart Disease and Stroke
ABCs of Heart Disease
Kidney Damage
Nerve Damage
Sleep Apnea
Blindness or Vision Problems
Celiac Disease



Connect with Others

Discuss healthy eating habits in our "Eating Right" Message Boards.

Visit the Message Boards

Home > Living With Diabetes > Complications > Men's Health > Serious Health Implications

Serious Health Implications

EMAIL PRINT SHARE

Diabetes can cause far-reaching health implications like heart disease, nerve damage and kidney damage. Amputation, blindness and even death can all result from not properly diagnosing or treating diabetes. Tackle these issues head-on and start by arming yourself with knowledge of these serious complications.

Heart Disease and Stroke



If you have diabetes, you are at risk for having a heart attack or stroke.

ABCs of Heart Disease



Know your ABCs so you can maintain a healthy heart and manage your diabetes.

Kidney Damage

Reduce the risk of early kidney disease by controlling your blood glucose and blood pressure.

Neuropathy (Nerve Damage)

Nerve damage from diabetes called diabetic neuropathy can lead to many kinds of problems.

Blindness or Vision Problems

Diabetes can damage the blood vessels of the eye, potentially leading to blindness.

Sleep Apnea

Are you ever jolted awake by the sound of your own snoring? Talk to your doctor about obstructive sleep apnea (OSA).

Gum Disease

Protect yourself from gum disease through good oral hygiene and diabetes management.

Why Did I Get Diabetes?



Understanding the causes (and why it's not your fault).

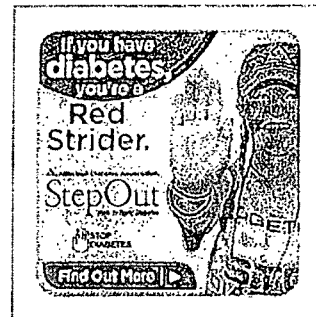
Details

Hispanic Heritage



Sept. 15 to Oct. 15 is Hispanic Heritage Month

Details



Five Secrets to Stop Diabetes



Check out these healthy tips to help prevent type 2 diabetes

Details

IN MY COMMUNITY



Feria de Salud

Get all the details on this exciting event here.

DONATE



Bank of America ADA Card

Help Stop Diabetes by signing up for a Bank of America Visa Card and Checking Program.

DONATE



It's as easy as 1, 2, 87

Join the movement now and Dial V8 Splash® will donate \$5.

NEWS & RESEARCH



Meet the Researchers

Learn more about ADA Researchers

DIABETES BASICS



Losing Weight Can Help Stop Diabetes

Watch the new Checkup America video.

Follow us on Twitter, Facebook, Flickr and YouTube



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American Diabetes Association 1701 North Beauregard Street Alexandria, VA 22311 1-800-DIABETES





For more information, Please visit www.diabetes.org

Kidney Damage

The kidneys contain millions of tiny blood vessel clusters that filter waste from your blood. Diabetes can damage this delicate filtering system. Severe damage can lead to kidney failure or irreversible end-stage kidney disease, requiring dialysis or a kidney transplant.

The kidneys work hard to make up for the failing capillaries so kidney disease produces no symptoms until almost all function is gone. Also, the symptoms of kidney disease are not specific. The first symptom of kidney disease is often fluid buildup. Other symptoms of advanced kidney disease include loss of sleep, poor appetite, upset stomach, weakness, and difficulty concentrating.

Diabetic kidney disease can be prevented by keeping blood glucose in your target range. Research has shown that good blood glucose control reduces the risk of early kidney disease and reduces the risk of progressing to more severe kidney problems by half.

Another important factor to prevent kidney disease is good blood pressure control. High blood pressure has a dramatic effect on the rate at which the disease progresses. Four ways to lower your blood pressure are losing weight, eating less salt, avoiding alcohol and tobacco, and getting regular exercise. In addition, most men with diabetes need medications to treat their high blood pressure. Several types of blood pressure medication can specifically protect the kidneys from ongoing damage.

It is vital to see your health care team regularly. They can check your blood pressure, urine (for protein), blood (for waste products), and help you manage your diabetes to protect your kidneys.

American Diabetes Association 1701 North Beauregard Street Alexandria, VA 22311 1-800-DIABETES
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For more information, Please visit www.diabetes.org

Depression

- People with diabetes are at greater risk for depression.
- Poor diabetes control can cause symptoms that look like depression.
- If physical causes are ruled out, you may be referred to a specialist for mental health treatment, including psychotherapy and antidepressant medication.

Feeling down once in a while is normal. But some people feel a sadness that just won't go away. Life seems hopeless. Feeling this way most of the day for two weeks or more is a sign of serious depression.

Does diabetes cause depression?

At any given time, most people with diabetes do not have depression. But studies show that people with diabetes have a greater risk of depression than people without diabetes. There are no easy answers about why this is true.

The stress of daily diabetes management can build. You may feel alone or set apart from your friends and family because of all this extra work.

If you face diabetes complications such as nerve damage, or if you are having trouble keeping your blood sugar levels where you'd like, you may feel like you're losing control of your diabetes. Even tension between you and your doctor may make you feel frustrated and sad.

Just like denial, depression can get you into a vicious cycle. It can block good diabetes self-care. If you are depressed and have no energy, chances are you will find such tasks as regular blood sugar testing too much. If you feel so anxious that you can't think straight, it will be hard to keep up with a good diet. You may not feel like eating at all. Of course, this will affect your blood sugar levels.

Spotting Depression

Spotting depression is the first step. Getting help is the second. If you have been feeling really sad, blue, or down in the dumps, check for these symptoms:

- Loss of pleasure
You no longer take interest in doing things you used to enjoy.
- Change in sleep patterns
You have trouble falling asleep, you wake often during the night, or you want to sleep more than usual, including during the day.
- Early to rise
You wake up earlier than usual and cannot get back to sleep.
- Change in appetite
You eat more or less than you used to, resulting in a quick weight gain or weight loss.

- Trouble concentrating
You can't watch a TV program or read an article because other thoughts or feelings get in the way.
- Loss of energy
You feel tired all the time.
- Nervousness
You always feel so anxious you can't sit still.
- Guilt
You feel you "never do anything right" and worry that you are a burden to others.
- Morning sadness
You feel worse in the morning than you do the rest of the day.
- Suicidal thoughts
You feel you want to die or are thinking about ways to hurt yourself.

If you have three or more of these symptoms, or if you have just one or two but have been feeling bad for two weeks or more, it's time to get help.

Getting Help

If you are feeling symptoms of depression, don't keep them to yourself. First, talk them over with your doctor. There may be a physical cause for your depression.

Poor control of diabetes can cause symptoms that look like depression. During the day, high or low blood sugar may make you feel tired or anxious. Low blood sugar levels can also lead to hunger and eating too much. If you have low blood sugar at night, it could disturb your sleep. If you have high blood sugar at night, you may get up often to urinate and then feel tired during the day.

Other physical causes of depression can include the following:

- Alcohol or drug abuse
- Thyroid problems
- Side effects from some medications

Do not stop taking a medication without telling your doctor. Your doctor will be able to help you discover if a physical problem is at the root of your sad feelings.

Mental Health Treatment

If you and your doctor rule out physical causes, your doctor will most likely refer you to a specialist. You might talk with a psychiatrist, psychologist, psychiatric nurse, licensed clinical social worker, or professional counselor. In fact, your doctor may already work with mental health professionals on a diabetes treatment team.

All of these mental health professionals can guide you through the rough waters of depression: In general, there are two types of treatment:

- Psychotherapy, or counseling
- Antidepressant medication

Psychotherapy

Psychotherapy with a well-trained therapist can help you look at the problems that bring on depression. It can also help you find ways to relieve the problem. Therapy can be short term or long term. You should be sure you feel at ease with the therapist you choose.

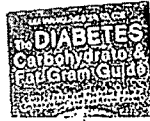
Medication

If medication is advised, you will need to consult with a psychiatrist (a medical doctor with special training in diagnosing and treating mental or emotional disorders). Psychiatrists are the only mental health professionals who can prescribe medication and treat physical causes of depression.

If you opt for trying an antidepressant drug, talk to the psychiatrist and your primary care provider about side effects, including how it might affect your blood sugar levels. Make sure that the doctors will consult about your care when needed. Many people do well with a combination of medication and psychotherapy.

If you have symptoms of depression, don't wait too long to get help. If your health care provider cannot refer you to a mental health professional, contact your local psychiatric society or psychiatry department of a medical school, or the local branch of organizations for psychiatric social workers, psychologists, or mental health counselors. Your local American Diabetes Association may also be a good resource for counselors who have worked with people with diabetes.

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Men's Health

Serious Health Implications

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Blindness or Vision Problems

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Diabetes can damage the blood vessels of the eye, potentially leading to blindness. While those with diabetes are at an increased risk of vision problems, most people with diabetes have no or only minor eye disorders.

Eye Disorders include:

- **Retinopathy** – Also known as damage to the blood vessels in the back of the eye, is more common if you have had diabetes a long time, or if your blood glucose or blood pressure haven't been under good control.
- **Glaucoma** – Occurs when pressure builds up in the eye. Vision is gradually lost because the retina and nerve are damaged. People with diabetes are 40% more likely to suffer from glaucoma than people without diabetes. The longer someone has had diabetes, the more common glaucoma is. Risk also increases with age. There are several treatments for glaucoma, including drugs that reduce pressure in the eye as well as surgical options.
- **Cataracts** – People with diabetes are 60% more likely to develop cataracts. People with diabetes also tend to get cataracts at a younger age and have them progress faster. With cataracts, the eye clouds, blocking OUT light. To help prevent and deal with mild cataracts, wear sunglasses outside and use glare-control lenses in your glasses.

Don't forget to get an annual dilated eye exam by an optometrist or ophthalmologist. Many eye problems are silent until they are advanced, but early detection and treatment truly saves vision.

Emotional Health

Feeling blue? Don't be afraid to share sadness, anxiety or depression.

Diet & Exercise

Prevent heart disease, high blood pressure and obesity by eating well and getting active.

Sexual Health

Seek help if diabetes affects your sex life and your relationships.

Why Did I Get Diabetes?



Understanding the causes (and why it's not your fault).

[Details](#)

Hispanic Heritage



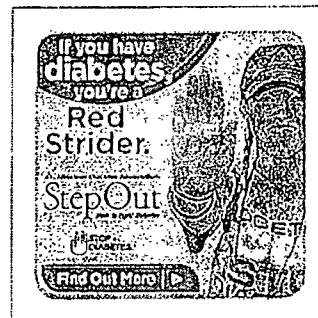
Sept. 15 to Oct. 15 is Hispanic Heritage Month

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Discuss healthy eating habits in our "Eating Right" Message Boards.

Visit the Message Boards



Five Secrets to Stop Diabetes



Check out these healthy tips to help prevent type 2 diabetes

[Details](#)

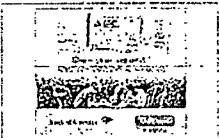
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Feria de Salud

Get all the details on this exciting event here.

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Help Stop Diabetes by signing up for a Bank of America Visa Card and Checking Program.

DONATE



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Join the movement now and Diet V8 Splash® will donate \$5.

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Meet the Researchers

Learn more about ADA Researchers

DIABETES BASICS



Losing Weight Can Help Stop Diabetes

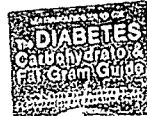
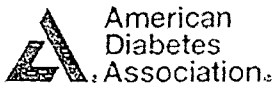
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Men's Health

Serious Health Implications

Heart Disease and Stroke

ABCs of Heart Disease

Kidney Damage

Nerve Damage

Sleep Apnea

Blindness or Vision Problems

Celiac Disease

[Home](#) > [Living with Diabetes](#) > [Complications](#) > [Men's Health](#) > [Serious Health Implications](#)

Heart Disease and Stroke

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Heart Disease and Stroke

If you have diabetes, you are at risk for having a heart attack or stroke. These strike people with diabetes more than twice as often as people without diabetes.

Coronary artery disease is caused by a narrowing or blocking of the blood vessels that go to your heart. It's the most common form of heart disease. Your blood carries oxygen and other needed materials to your heart. Blood vessels to your heart can become partially or totally blocked by fatty deposits. A heart attack occurs when the blood supply to your heart is suddenly reduced or cut off. A stroke occurs when blood vessels to a part of your brain is suddenly cut off by fatty deposits or a blood clot.

Making changes to your lifestyle can help prevent against heart disease and stroke. Make healthy food choices and get active.

✓ [Learn the ABCs of Heart Disease](#)

Why Did I Get Diabetes?



Understanding the causes (and why it's not your fault).

[Details](#)

Hispanic Heritage



Sept. 15 to Oct. 15 is Hispanic Heritage Month

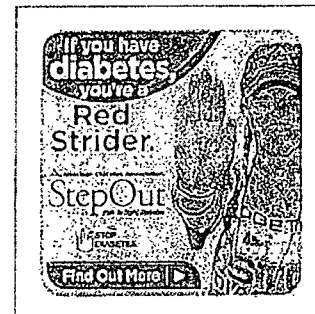
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Five Secrets to Stop Diabetes



Check out these healthy tips to help prevent type 2 diabetes

[Details](#)

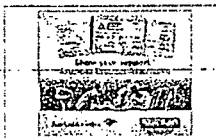
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Feria de Salud

Get all the details on this exciting event [here](#).

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NEWS & RESEARCH



Meet the Researchers

Learn more about ADA Researchers

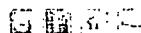
DIABETES BASICS



Losing Weight Can Help Stop Diabetes

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For more information, Please visit www.diabetes.org

Nerve Damage

Diabetes Getting On Your Nerves?

Nerves are the messengers of the body. They provide your brain with information about pain, temperature and touch. They talk to your muscles and tell them how and when to move and they control body systems that digest food, pass urine and they control erections. Over time excess glucose can injure the walls of the tiny blood vessels that nourish your nerves, especially in the legs. This can cause tingling, numbness, burning or pain that usually begins at the tips of the toes or fingers and over a period of months or years gradually spreads upward. About half of all people with diabetes have some form of nerve damage. It is more common in those who have had the disease for a number of years. Nerve damage from diabetes is called diabetic neuropathy.

Take the following steps to prevent or delay nerve damage:

- Meal planning, physical activity and medications, if needed, all can help you reach your average glucose target range.
- Track your blood glucose levels. Use a blood glucose meter to help you make decisions about day-to-day care. Get an A1C test at least twice a year to find out your average blood glucose for the past 2-to-3 months.
- Report any possible signs of diabetic neuropathy, such as pain or numbness in your feet. It is especially important to report any sore or break in the skin of your feet.
- If you have problems, get treatment right away. Early treatment can help prevent more problems later on. For example, if you take care of a foot infection early, it can help prevent amputation.
- Take good care of your feet. Check your feet every day. If you no longer can feel pain in your feet, you might not notice a foot injury. Instead, use your eyes to look for problems. Use your hands to feel for hot or cold spots, bumps or dry skin. Look for sores, cuts or breaks in the skin. Also check for corns, calluses, blisters, red areas, swelling, ingrown toenails and toenail infections.
- Protect your feet. If your feet are dry, use a lotion on your skin but not between your toes. Wear shoes and socks that fit well and wear them indoors and out. Use warm water to wash your feet, and dry them carefully afterward.
- Get special shoes if needed. If you have foot problems, Medicare or other insurance may pay for shoes. Ask your health care team about it.
- If you have diabetic neuropathy, talk to a diabetes clinical exercise expert who can guide you, as some physical activities are not safe for people with neuropathy.
- Make sure your health care provider checks your feet at every visit.

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Exhibit 8. Financial Agreement between Charles Lea Center and Carolyn Brown

STATE OF SOUTH CAROLINA)
)
COUNTY OF SPARTANBURG)

AGREEMENT

WHEREAS, The Charles Lea Center for Rehabilitation and Special Education, Inc. ("Charles Lea Center") and Carolyn Bearden Brown ("Brown") have been involved in a dispute concerning a financial accounting for Peter Brown, for the period of time from November 1998 through June 30, 2001; and

WHEREAS, Peter Brown is a person with disabilities and special needs receiving services from the South Carolina Department of Disability and Special Needs ("DDSN"); and

WHEREAS, because of Peter Brown's condition, Brown has been judicially appointed guardian for Peter Brown and has previously applied for and been made the Social Security payee for Peter Brown by the Social Security Administration; and

WHEREAS, the financial dispute between The Charles Lea Center and Brown resulted in an audit by DDSN, which was supplemented by the Charles Lea Center, both of which have aided in the resolution of this dispute; and

WHEREAS, the parties hereto desire to resolve their claims and counterclaims and disputes as addressed in the DDSN audit dated September 14, 2001, and supplement response by The Charles Lea Center, as well as any and all other disputes which may have existed between the parties as of June 30, 2001; and

WHEREAS, the parties represent and warrant that they have the right to settle all claims and disputes which are or could have been asserted by them on or before June 30, 2001;

NOW, THEREFORE, for and in consideration of the premises and the terms set forth below, the parties agree as follows:

1. The Charles Lea Center shall pay to or for the benefit of Peter Brown, \$4,030.49 to resolve all financial disputes through June 30, 2001. Brown wishes for these payments to be made in a manner which she has determined will not affect other resources of Peter Brown. The Charles Lea Center is in agreement to reimburse the monies in a form and fashion that will not adversely affect Peter, but does not express any opinion as to how these repayments will affect other resources of Peter. Based solely upon the investigation, research and direction of Brown, the parties agree to pay to reimburse these funds as follows:

A. So long as Peter Brown is employed at Palmetto Textiles or in a comparable job, the \$4,030.49 will be paid to Brown for the benefit of Peter Brown, without interest, at a rate of \$125.00 per month, beginning on the first of the month after this agreement is executed.

B. If Peter Brown is not employed as set out in paragraph A above, and during such unemployment, The Charles Lea Center will pay Brown for the benefit of Peter, the amount due, without interest, at a rate of \$166.00 per month beginning on the first of the

JUL-10-02 REV 01:00 PM

month that The Charles Lea Center receives written notice from Brown directing that these payments be so made.

C. The method of payment by The Charles Lea Center to Brown shall be by crediting the account of Peter on a monthly basis with the amount of such credit determined according to either paragraphs A or B above.

2. The Charles Lea Center agrees that it will take no action to become the Social Security payee for Peter Brown based upon Brown's actions prior to October 31, 2001.

3. There is hereby established a Fee Dispute Resolution Process regarding the payment of non-payment of invoices submitted by The Charles Lea Center to Brown. This process is adopted with all parties believing that it is acceptable to and will not conflict with the rules and regulations of DDSN or other controlling authority. In establishing this Fee Dispute Resolution Process, it is specifically acknowledged that the parties have previously established an Internal Financial Plan for Peter Brown which was adopted by Peter's ISP Team in October 1998 (a copy is attached as Exhibit A). The parties agree that they are bound by this Plan. An explanation of interactions of paragraph 8 of the Plan with this Fee Dispute Resolution Process is set forth in paragraph 8.A & B below. The Fee Dispute Resolution Process is as follows:

A. The Associate Director for Finance/Administration, or her designee, will submit invoices to Mrs. Brown monthly around the 15th, an itemized statement, including itemized receipts, for the previous month.

B. Brown shall respond by the end of each month stating any objections she may have as to the invoice and including with the response, her check for the undisputed amount. The check shall be made out to The Charles Lea Center.

C. Within 10 days of the receipt of Brown's objections, Brown and the Associate Executive Director, shall attempt to resolve the dispute by personal telephone call or personal conversation.

D. If there is no resolution as to the objections, then the matter with all documentation, shall be given to the Executive Director of The Charles Lea Center and he shall issue his decision within 10 days.

E. If there is no resolution as to the objection after the Executive Director has issued his decision, then the parties shall follow the Appellate procedures as set forth in the "Internal Grievements/Appeal Procedures for Applicants and Service Recipients, Reference No. 535-11-PD" or its updates or revisions.

4. Both parties affirmatively state that they fully understand the terms of this agreement and are freely and voluntarily, without coercion, entering into it.

5. Each party specifically acknowledges that they have consulted with and been advised by legal counsel in the negotiation of this agreement and that they are satisfied with their representation. Notwithstanding this representation, the parties agree to be fully bound by this agreement whether or not they may later disagree with or dispute the legal advice which they have obtained.

6. This agreement shall be effective immediately upon execution.

7. It is understood and agreed that any party to this agreement may plead this agreement as a complete defense and barred to any action, claim or demand brought in contravention to the terms of this agreement.

8. This agreement is governed by the laws of the State of South Carolina.

9. No provision of this agreement or of any documents delivered pursuant to it, shall be construed against any party or their counsel, merely because such party or counsel initially drafted such provision or document. This agreement shall be deemed to have been jointly drafted by the parties for contract construction purposes.

10. This agreement represents the entire agreement between the parties. It supercedes all prior negotiations, representation, letters or agreements between the parties either oral or written. This agreement may be amended only by a written instrument, specifically designated as an amendment to this agreement and executed by all of the parties hereto.

11. Each party warrants and represents to the other that the parties signing this agreement is dually authorized to sign and that this agreement is binding and enforceable to each of the respective parties, their heirs, successors or assigns.

12. In the event that any provision of this agreement is deemed or ruled to be unenforceable, all of the other provisions and terms shall remain in full force and effect.

This agreement is executed in two counterparts, each of which shall be an original.

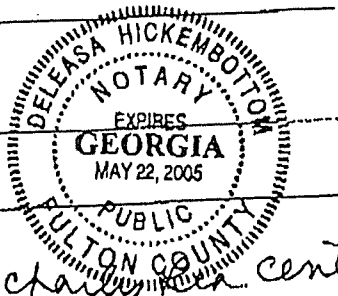
Accepted and agreed to this 10 day of May, 2002.

IN THE PRESENCE OF:

Deleasa Hickembottom

The Charles Lea Center for Rehabilitation
and Special Education, Inc.

Ann O. Brumfield
By:
Its: Executive Director



Carol Bearden Brown
Carolyn Bearden Brown

ast to the Charles Lea Center:

E. Bond

CHARLES LEA CENTER
INTERNAL FINANCIAL MANAGEMENT PLAN
FOR
PETER BROWN

1. The Charles Lea Center will establish a bank account in Charles Lea Center's name for Peter Brown.
2. Co-signers approved will be Suzan Mason, QMRP Supervised Living. Elaine Bond, Associate Executive Director Finance and Administration or Al Brumfield, Executive Director.
3. Monthly bank reconciliation will be performed by Doris Wilson, Operations Coordinator Supervised Living.
4. Monthly reconciliations will be reviewed by the Finance Office.
5. An approval list of monthly expenditures will be provided to Bill Chidester, Associate Executive Director, Living Support Services, by Guardian. Mr. Chidester will forward approval to client funds office.
6. Suzan Mason, QMRP will pay Peter's bills from the Charles Lea Center account for Peter Brown as authorized by Guardian, Carolyn Bearden-Brown. The following internal procedures will be utilized in purchasing admission tickets and providing participation funds for Peter.
 - a. When local Spartanburg activities are scheduled on Tuesdays, Suzan Mason will be responsible for seeing that tickets are obtained no later than Wednesday p.m. (This was revised January 1999 because the Enhanced Staff Person's scheduled changed). The Center is committed to support Peter's attendance at these various ticketed events.
 - b. When there are other advance tickets that are in demand and must be purchased in order to guarantee tickets, Suzan Mason, in her absence, her designee will order the tickets via credit card the Monday or Tuesday the event is requested for the future event.

- c. The authorized community activity and work activity funds will be placed in Peter's cash box each Tuesday morning. Funds will be maintained in Whispering Pines' office per authorized amounts as indicated by monthly authorization by Mrs. Brown and as agreed upon at annual staffing on October 21, 1998. A minimum of \$30.00 will be kept in an Activity Fund at the SLP office. Enhanced Staff Person will assist Peter to return all money not spent to Activity Fund upon return to Whispering Pines Office.

7. Suzan Mason QMRP will provide copies of the check register and Receipts to the Finance Office, (attn: Misti Harris) at the end of each month.
8. The Finance Office, per agreement, will submit to Mrs. Brown, monthly around the 15th, an itemized statement, including itemized receipts, for the previous month. Mrs. Brown agrees to reimburse the Center by the last week of each month. The check made out to the Charles Lea Center will be brought to the attention of the Client Funds Office.
9. Client funds Office will deposit check into the Charles Lea Center account for Peter Brown.

Revised: 11/04/98

11/12/98

11/3/99

Adopted by PCP Team: 10/21/98

Exhibit 9. Orders of Dr. Reel

Eastside Family Physicians

North Grove Medical Park, suite 1200
1330 Boiling Springs Road
Spartanburg, S.C. 29303
864-591-5900

Austin R. McElhaney, Jr., M.D.

Tod R. Reel, M.D.

June 2, 2010

To Whom It May Concern:

Please do not allow Peter Brown to self administer his medications of any kind.

A handwritten signature in black ink, appearing to read 'Tod R. Reel', with a stylized, cursive script.

Tod R. Reel, M.D.

Eastside Family Physicians

NGMP Suite 1200 1330 Boiling Springs Road, Spartanburg, SC 29303
864-591-5900 Fax: 864-529-3358

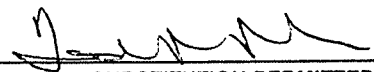
Name PETER C BROWN Date 10/25/2010
Addr 5225 CLEMSON AVE NUMBER 128 DOB 11/02/1967
City COLUMBIA, SC 29206 (803)743-0646

Rx DIET REQUIREMENTS Monitor pt's diet to insure minimum of 2500 calories daily

Disp ***_***

Refill ***_***

Dispense as Written



SUBSTITUTION PERMITTED

Tod R Reel MD

DEA:BR0979522 LIC:13940 NPI:1619952736

Eastside Family Physicians

NGMP Suite 1200 1330 Boiling Springs Road, Spartanburg, SC 29303
864-591-5900 Fax: 864-529-3358

Name PETER C BROWN

Date 10/25/2010

Addr 5225 CLEMSON AVE NUMBER 128

DOB 11/02/1967

City COLUMBIA, SC 29206

(803)743-0646

Rx ACTOS 45 MG TABS 1poqd

Generic: PIOGLITAZONE HCL

Disp ***30***

Refill ***5***

Dispense as Written


SUBSTITUTION PERMITTED

Tod R Reel MD

DEA:BR0979522 LIC:13940 NPI:1619952736

Eastside Family Physicians

NGMP Suite 1200 1330 Boiling Springs Road, Spartanburg, SC 29303
864-591-5900 Fax: 864-529-3358

Name PETER C BROWN

Date 10/25/2010

Addr 5225 CLEMSON AVE NUMBER 128

DOB 11/02/1967

City COLUMBIA, SC 29206

(803)743-0646

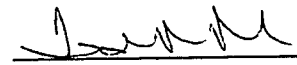
Rx GLUCOPHAGE XR 500 MG TB24 4 tablets by mouth with PM meal

Generic: METFORMIN HCL

Disp ***120***

Refill ***5***

Dispense as Written


SUBSTITUTION PERMITTED

Tod R Reel MD

DEA:BR0979522 LIC:13940 NPI:1619952736

Eastside Family Physicians

NGMP Suite 1200 1330 Boiling Springs Road, Spartanburg, SC 29303
864-591-5900 Fax: 864-529-3358

Name PETER C BROWN

Date 10/25/2010

Addr 5225 CLEMSON AVE NUMBER 128

DOB 11/02/1967

City COLUMBIA, SC 29206

(803)743-0646

Rx ZOCOR 20 MG TABS 1 tablet by mouth daily at bedtime. Do not take before 8 pm

Generic: SIMVASTATIN

Disp ***30***

Refill ***5***

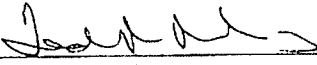
Dispense as Written


SUBSTITUTION PERMITTED

Tod R Reel MD

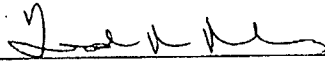
DEA:BR0979522 LIC:13940 NPI:1619952736

October 22, 2010, due to his diabetes, it is essential that Peter Brown engage in physical exercise, such as swimming, often during the week.



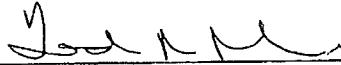
Tod R. Reel, M.D.

October 22, 2010, due to Peter Brown's diagnosis of hypoglycemia and his impaired ability to understand value concepts of money, I request the current System of Money Management in Peter's Person Centered Plan be continued. He is not to manage his allocated canteen funds independently of Staff supervision.



Tod R. Reel, M.D.

October 22, 2010, OK for Peter Brown to take AM Meds upon awakening.



Tod R. Reel, M.D.

Exhibit 10. Declaration of Carolyn Brown and Lennie Mullis related to Peter's Plan Meeting

STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

**DECLARATION OF CAROLYN BROWN AND LENNIE MULLIS
RELATED TO
PLAN MEETING OF PETER BROWN HELD OCTOBER 22, 2010**

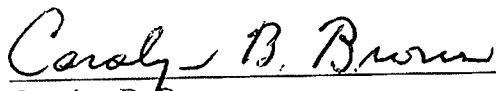
I attended the plan meeting of Peter Brown which was held at his apartment on October 22, 2010. This meeting had been initially scheduled by the Charles Lea Center staff to occur on October 18, 2010 and was rescheduled by agreement between the guardian of Peter Brown and Marcia Jagers. The meeting was scheduled to begin at 10:30 in the apartment of Peter Brown. In attendance were Peter Brown, his legal guardian, Carolyn Brown, his psychological services provider, Lennie Mullis and Patricia Harrison. The Charles Lea Center nurse, Dee Blackwell, arrived in Peter's apartment at approximately 10:25. Jeannette Smith arrived at the scheduled time. These persons were waiting in Peter's apartment when Armilla Moore, Associate Executive Director of the Charles Lea Center, Bobbie Higgins and Marcia Jagers arrived at Peter's door. Ms. Moore refused to enter the room when she saw that an attorney was present and refused to participate in Peter's plan meeting unless his attorney left his apartment. Patricia Harrison has attended plan meetings in past years which have been held in Peter's apartment, the home of the guardian or in Ms. Harrison's office.

Patricia Harrison represents Peter's guardian in litigation involving the South Carolina Department of Disabilities and Special Needs and the South Carolina Department of Health and Human Services. The Charles Lea Center is not a party to that litigation and I am not aware of Patricia Harrison being involved in any pending litigation against the Charles Lea Center.

When Ms. Moore refused to hold Peter's meeting as scheduled and departed with her staff, we proceeded with Peter's plan meeting and agreed on goals and objectives for the coming year.

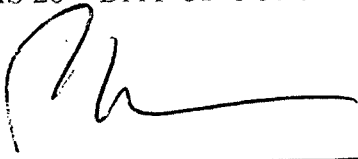
On October 25, 2010, Carolyn Brown was informed that Peter's service coordinator, Jackie Walker, would no longer be providing service coordination services for DDSN. It was later learned that other families had been informed that Ms. Walker would no longer be a provider of service coordination services before the meeting, but Ms. Moore did not advise us of that fact before she left the premises.

I swear and affirm that the statements contained in this declaration are true and correct to the best of my knowledge. Executed this 26th day of October, 2010.


Carolyn B. Brown


Lennie S. Mullis

SWORN TO BEFORE ME
THIS 26TH DAY OF OCTOBER, 2010

A handwritten signature in black ink, consisting of a large, stylized capital 'P' followed by a cursive 'h' and a long horizontal stroke.

My commission expires November 19, 2017

Exhibit 11. Excerpts from transcript of 2006 "Fair Hearing" before SCDHHS Hearing Officer
Barry Streeter re fear of reprisal against Jackie Walker, Service Coordinator

THE STATE OF SOUTH CAROLINA
IN THE ADMINISTRATIVE LAW COURT

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

Barry W. Streeter, Hearing Officer

Docket Number: 07-ALJ-08-0180-AP

Peter Brown,

Appellant,

vs.

South Carolina Department of Health and
Human Services,

Respondent.

RECORD ON APPEAL

Volume 1'

Byron Roberts
SC Department of Health and
Human Services
Office of General Counsel
P.O. Box 8206
Columbia, South Carolina 29206
(803) 898-2795
(803) 255-8210 Fax
RobertsB@scdhhs.gov
ATTORNEY FOR RESPONDENT

1 HARRISON: We've got one more witness.
2 STREETER: Okay. Let's take a reasonable lunch break then and be back here at
3 2:30.
4 MRS. BROWN: Bryan doesn't have to come back, does he?
5 STREETER: No. We'll be back at 2:30, ready to rock and roll. We are off the
6 record.
7 All right, we're on the record. We have had a discussion off the
8 record as to some objections.
9 HILL: Could we...
10 STREETER: And I'll explain as follows that Mrs. Harrison has indicated that
11 Mrs. Walker, who is an independent service coordinator—you can
12 stay for right now, Mrs. Brown, Mrs. Walker who is an
13 independent service coordinator and is the service coordinator for
14 Peter Brown, she has some concerns that Mrs. Armilla Moore who
15 is working for Charles Lea Center and is in charge of habilitation
16 or residential services for the center might have a chilling affect on
17 the testimony of Mrs. Walker because it's asserted that Charles
18 Lea Center has some control over her contract in terms of the fact
19 that they have to approve as a provider. We've had a long
20 discussion here with various parties. Mr. Hill has provided us with
21 Richard—is it Winnick?
22 LAWRENCE: Winnick.
23 STREETER: And Mr. Winnick is an expert on how this process works. Frankly,
24 I find the process completely convoluted in how the money flows
25 from Health and Human Services to DDSN to Spartanburg and
26 who gets it and to whom and in fact no one seems to be able to
27 really clarify it too easily. At this particular point, it appears that I
28 have—that Health and Human Services has jurisdiction over a
29 problem where Mrs. Walker might not be approved as an
30 independent service coordinator by DDSN, her first appeal is to
31 DDSN, her next appeal is to Health and Human Services which

1 would come to me. The attorneys have stipulated that in the event
2 of a problem for Mrs. Walker in terms of being reinstated or
3 having her license suspended by DDSN that they have no problem
4 with the appeals process going through DDSN to Health and
5 Human Services and that by virtue of the fact that I have been
6 involved in this case which is the case where retribution to Mrs.
7 Walker is feared, that I would hear that matter. There's been no
8 objection by Respondent's attorneys, is that right?

9 HILL: Correct.

10 ROBERTS: That's correct.

11 STREETER: And Petitioner's attorney doesn't have a problem with me hearing
12 that case in that event.

13 HARRISON: Not at all.

14 STREETER: Okay. And that is some assurance for Mrs. Walker. Now I still
15 have the problem of Armilla Moore and, you know, the parties, the
16 attorneys have been unable to resolve the squabble so I'm going to
17 give everybody a chance to state their objections because based on
18 the information before me, what I'm hearing from Mr. Winnick is
19 that the process is bound by DDSN's approval. At this point, Mrs.
20 Harrison strongly disagrees with that. The parties can't agree on
21 what the status of the law is and so I'm going to allow everybody
22 to have their objection but at this point if Mrs. Walker feels there's
23 a chilling affect by the presence of Armilla Moore and since fair is
24 fair, I'm going to have the non-attorney parties, except for the
25 witness, removed from the hearing room and that will be Armilla
26 Moore and Carolyn Brown. Now various parties wish to object in
27 order and I will begin with Mrs. Harrison. Let's hear it.

28 HARRISON: We have no objections.

29 STREETER: Okay, Mr. Hill.

30 HILL: No objection.

31 STREETER: All right. Mr. Roberts.

1 ROBERTS: I'm going to—I have an objection but I'm going to let Mr.
2 Lawrence speak to the objection because I join in his objection.
3 STREETER: All right, Mr. Lawrence, let's hear it.
4 LAWRENCE: Well, I do have an objection. First off, we are an open court State
5 and that means an open hearing State and persons that are before a
6 tribunal need to have the oppor—the right to be here and the right
7 to participate in the proceedings that are going on. Mrs. Miller is a
8 representative of the Charles Lea Center and the Charles Lea
9 Center is definitely involved in this matter. Under the open court
10 system I know of very few reasons to exclude a party from the
11 proceeding. And I know they even passed laws to allow a child
12 not to be in front of an abuser in the criminal side of matters and I
13 know that you can sequester witnesses from courtrooms but
14 sequestration is applied to witnesses, not to the parties. In this
15 instance, I have to rely on Mrs. Moore to help me with the jargon
16 that these people in disabilities and special needs use and also to
17 understand the procedure of the service coordinator. And the
18 service coordinator has been with this case for many, many years
19 and we've also gone through convoluted testimony regarding the
20 whole procedure and it is difficult to understand so we have a
21 service coordinator that's an expert and I have Mrs. Moore who's
22 an expert that can help me be able to ask questions to see if what's
23 being said is accurate or if there is some problems with it so I
24 absolutely have to rely on her to be here to help me in the cross-
25 examination. On top of that, if somebody's requesting witnesses
26 be removed from the room I think it's up to them to state the
27 grounds. Now grounds have been stated that this might have a
28 chilling affect. I don't think any evidence has been produced other
29 than statements from lawyers that what chilling affect this would
30 have on her. I don't think chilling affect is enough grounds to
31 remove my client from the courtroom, from the hearing room. On

atty for
Charles Lea Center
not even a
party to
action

CLC was not
a party

1 top of that, she's a competitor with my client. My client does not
2 have any rights to disapprove of her—of her credentials and if she
3 has any credential problems, she has an appellant procedure
4 through DDSN. Any monies that go to her that come from DDSN
5 are funneled to the Charles Lea Center and we have no right to
6 interfere with that whatsoever so I, I, uh, I would like to enter my
7 objection of my client not being able to be here with me.

8 STREETER: All right, Mrs. Harrison, let's hear your response.

9 HARRISON: Mrs. Walker's contract must be approved by the Charles Lea
10 Center Board. They write her check and they're also a competitor.
11 Mr. Lawrence has represented the Charles Lea Center for probably
12 fifteen years and is a former board member. He's been there
13 longer than Mrs. Moore has. Mrs. Moore's been there, I believe,
14 two years. I think the chilling affect by far overrides, um, and,
15 and, this is a case, Peter Brown versus Health and Human Services,
16 you know, that the DDSN policies, they don't have reg's, but the
17 policies say that the provider doesn't even have a say so in what
18 services are included in the plan. The policies say that the plan is
19 created separate from the providers so they shouldn't—I'm not
20 even sure that the Charles Lea Center should be here but I feel like
21 the chilling affect overrides, um overrides any, any, um, um,
22 prejudice to the Charles Lea Center.

23 HILL: If I may I'd like to withdraw my non-objection and object too
24 because I see a problem here with Appellant's argument. She
25 stated something that was actually contrary to what Mr. Winnick
26 said. Mr. Winnick, as I recall said that Charles Lea Center had no
27 approval process in the contract for Mrs. Walker and Appellant has
28 argued that they do and on that basis alone it's, in my mind, a
29 misrepresentation of the facts of this issue and besides that it's my
30 understanding that if there's any cross examination of Mrs. Walker

DDSN not a party -
only parties are P. Brown & HHS

1 it may be myself that will do it and Mrs. Moore may be my
2 assistant in this regard. So that's for the record.
3 STREETER: Mr. Winnick, do you have any religious belief that will keep you
4 from taking an oath to swear to tell me the truth?
5 WINNICK: No.
6 STREETER: Raise your right hand. Do you swear to tell me the truth, the whole
7 truth and nothing but the truth?
8 WINNICK: Yes.
9 STREETER: All right, Mr. Winnick, tell me and you're going to have to speak
10 up for me a little bit I think. Why don't you come up here?
11 WINNICK: Okay.
12 STREETER: What's your position here at DDSN?
13 WINNICK: I'm the Director of Cost Analysis.
14 STREETER: Okay, and you're familiar with the process for approving the
15 service coordinator?
16 WINNICK: I'm familiar with the process of approving qualified providers.
17 STREETER: Okay, and service coordinators are qualified providers?
18 WINNICK: Service coordination is one of the services that we approve private
19 entities to do.
20 STREETER: If DDSN finds that a person is qualified independent service
21 provider for Spartanburg area, does Charles Lea Center have the
22 authority to decide that they cannot provide services to people who
23 are Charles Lea Center clients?
24 WINNICK: No, Charles Lea has no say so in their consumer's choosing a
25 qualified provider who's authorized for that code.
26 STREETER: But the—but there is something that's called the approval of
27 Charles Lea Center, is there not?
28 WINNICK: I don't understand.
29 STREETER: It's been asserted by the attorneys here, or one of the attorneys
30 here that Charles Lea Center has to approve whether Mrs. Walker

1 can provide services in Spartanburg County because they are, in
2 essence, acting as the DDSN Board for Spartanburg County.
3 WINNICK: Charles Lea Center per our contract must contract with qualified
4 providers.
5 STREETER: They must contract with qualified providers?
6 WINNICK: They must, they must. And the Board approval process is just the,
7 um, some of our DSN Boards have given—delegated the ability to
8 contract to the executive directors; others make executive directors
9 take all contracts to the board. It's just...
10 STREETER: And that's the local DDSN Board. And you're talking about
11 ability to contract and so I have trouble. Explain to me why they
12 have anything to do with the ability to contract if state DDSN is
13 the person that or the entity that decides who's qualified as a
14 service provider or not. I'm having trouble with that language.
15 WINNICK: Okay.
16 STREETER: So explain that to me.
17 WINNICK: They're required to contract. It's just—I think it's just a matter of
18 who gets to sign the contract. The—some of the boards have
19 delegated the authority to sign off on any contract to the executive
20 director. Other boards make executive directors take contracts to
21 the board for approval. It's just a, um, I can't think of the word.
22 END OF SIDE 1, TAPE 3
23 BEGINNING OF SIDE 2, TAPE 3
24 STREETER: We're continuing on the record. Mr. Winnick, it's just a process
25 you talked about.
26 WINNICK: It's a process—it's a, it's—it's a local board process. They are
27 required to do that. If they refuse to subcontract with a qualified
28 provider, DDSN has the right to terminate the contract with the
29 board.

*Charles Lea Ctr
not a "local DDSN
board" under
statute*

1 STREETER: So Charles Lea Center can be terminated as the representative in
2 Spartanburg County if they refuse to contract with someone that
3 you have approved for services?
4 WINNICK: That would be the ultimate result if Charles Lea Center refuses to
5 follow the terms of their contract.
6 STREETER: All right, any questions for this witness, Mrs. Harrison?
7 HARRISON: If this process of approval by the board is meaningless, why is it
8 there?
9 WINNICK: I do not know.
10 HARRISON: But do you acknowledge that it is there. That the Board has to
11 approve Mrs. Walker's contract.
12 WINNICK: I am not familiar—I'm understanding through the conversation
13 here that's how it operates in Spartanburg, I do not know for a fact
14 whether or not they approve every single contract or not, I'm
15 talking about the board.
16 HARRISON: Is it not true that some of the boards have refused to enter in to
17 these contracts with qualified providers?
18 WINNICK: Some boards have refused to enter in the contracts and DDSN then
19 deals with the boards.
20 HARRISON: Okay, but is it not true that the Charles Lea Center could do the
21 same thing that these other boards have done?
22 WINNICK: I can't answer that. I don't know.
23 HARRISON: Thanks.
24 STREETER: Mr. Hill.
25 HILL: If I may ask a question. When you said that some boards refused
26 to enter a contract, that's not with service coordination. That
27 might be with—providers for psychological services or some other
28 type service, to your knowledge?
29 WINNICK: I don't know.

1 HILL: Okay. Appellant's attorney is heard that that Mrs. Walker is the
2 only approved service coordinator in South Carolina. Do you know
3 if that's true or not?

4 HARRISON: For, excuse me.

5 STREETER: Don't interrupt.

6 HILL: Do you know if that's true or not?

7 WINNICK: Mrs. Walker is the only approved private service coordinator in
8 Spartanburg County. There are other service coordination entities,
9 private service coordinator entities approved for services elsewhere
10 in the state.

11 HILL: Are they bound by county lines, service coordination? In other
12 words, can Mrs. Walker provide service coordination in Greenville
13 County or can some other service coordinator in another county
14 provide services in Spartanburg County?

15 WINNICK: I don't remember if Mrs. Walker is approved only for Spartanburg
16 County and if she's only approved for Spartanburg County, once
17 she's on the qualified provider list all she has to do is request to
18 expand—she's already approved as a qualified provider if she
19 wishes to expand to Greenville, Cherokee or whatever counties
20 around there all she has to do is write a letter to the Department
21 wishing to expand her geographic area.

22 HILL: That is to provide notice to potential consumers when they want to
23 engage her services. Is that true or false?

24 WINNICK: Will you repeat that?

25 HILL: And that's to provide the providers in those counties notice that
26 she's available to provide services so they can inform their
27 consumers that she's available for choice.

28 WINNICK: She would be—it would be, um, if she wanted to expand and once
29 it goes through the paperwork process, notification is sent out to
30 various—the DDSN boards and all of the local advocacy groups
31 and published on the DDSN's website.

1 HILL: To your knowledge, does Spartanburg County have any
2 meaningful input into whether or not Mrs. Walker continues her
3 contract?
4 WINNICK: No, they do not have any meaningful input.
5 HILL: All right. Thank you, sir.
6 STREETER: What was your want—what did you want to clear up?
7 HARRISON: Are there any...
8 STREETER: No questions, talk to me.
9 HARRISON: I'm sorry.
10 STREETER: Tell me what it is you want to clear up first.
11 HARRISON: There are no other independent service coordinators in the state
12 that I'm aware of for adults with mental retardation other than
13 autism. I think it was misleading that...
14 STREETER: All right, stop. I'll ask him. Are there other qualified service
15 providers—I mean, service coordinators in the State of South
16 Carolina for adults with mental retardation?
17 WINNICK: Yes.
18 HARRISON: Other than autism?
19 STREETER: And what was that? Other than autism? Mental retardation is not
20 autism. Somebody will throw a brick at me for that but they're
21 not. Okay. Sounds to me like, Mrs. Harrison, your client, I mean
22 not your client, your witness has got plenty of protection. I'm
23 willing to step in. Respondents have all agreed that because of the
24 nature of this hearing, that they're agreed that I'll hear it when it
25 comes to Health and Human Services. We've got testimony that
26 Charles Lea Center is performing a ministerial service at best.
27 Where's the problem? Remember now you're representing Peter
28 Brown.
29 HARRISON: We just want the truth to come out and we feel that the truth would
30 be more likely to come out if there's—if there's not the

1 participation of the competitor who also cuts the check and who
2 also this witness is dependent on to approve her contract.
3 STREETER: Mrs. Walker, I frankly don't remember at this point. Have I sworn
4 you in?
5 WALKER: Not this time.
6 STREETER: Do you have a religious belief that will keep you from taking an
7 oath?
8 WALKER: No.
9 STREETER: Raise your right hand. Do you swear to tell me the truth, the whole
10 truth and nothing but the truth?
11 WALKER: I do.
12 STREETER: All right, you've heard both on and off the record various
13 *did not ask* wrangling that's gone on. Do you feel that you cannot tell me the
14 *"are you* truth or do you feel that you are not going to be able to tell me the
15 *intimidated"* truth because of parties at this hearing?
16 WALKER: No, I don't feel that way.
17 STREETER: Okay. I think that pretty well takes care of it. If the witness
18 doesn't feel threatened I think that pretty well removes it from the
19 table. All right, in spite of the fact that I'm actually leaning or
20 leaned the other way, I'll let Mrs. Moore stay. I'll let Mrs. Brown
21 stay. Poor Mr. Winnick can leave if he has some—I'm sure he has
22 some other things to do. You weren't expecting to be called in
23 here today, sir. I appreciate your appearance.
24 WINNICK: I do have other duties at this time.
25 HARRISON: Would you mind getting me a list of other service coord—
26 independent service coordinators for people with adult...
27 STREETER: Off the record. We're back on the record. Mr. Winnick, I think
28 we need to clarify an issue that's come up. Are there other service
29 coordinators in the State of South Carolina who provide services
30 for adults with mental retardation that you know of?

1 WINNICK: I would need to check the data base to confirm. There are service
2 coordination providers other than J. B. Walker and Company that
3 provide adults but I have to check the population and age group
4 that they serve.

5 STREETER: All right, what do you mean in the context of adults, what
6 population and age group? Are there adults broken down into
7 different age?

8 WINNICK: You've got—well, age group is—could be 21 or less or six years
9 and under or it could be 21 and over. Population you could have
10 MRRD and autistic.

11 STREETER: So you could be over 18 and be an adult but be under the 21
12 classification or you could be over 21, is that...

13 WINNICK: Yeah, depends on what you want to call adult.

14 STREETER: Okay, all right. Thank you very much. We're off the record. All
15 right, we're back on the record and now ready to begin with Mrs.
16 Walker. Mrs. Harrison?

17 HARRISON: Okay, thank you. Mrs. Walker, would you—we've gone through
18 your occupa—name and occupation, we've gone through that.
19 What's your educational background?

20 WALKER: I have a Bachelor of Arts degree in Sociology and a Bachelor of
21 Arts in Human Services.

22 HARRISON: Okay, and your work history.

23 WALKER: In '84 I worked as an adult compensatory education instructor
24 teaching mentally handicapped adults basic education. In '84 I
25 came to the Charles Lea Center as a case manager and in '93 was
26 promoted to supervisor and stayed there until 2002 and then began
27 my own private service coordination.

28 HARRISON: Okay. How long have you been involved as a member of Peter
29 Brown's Circle of Support team. I know its changed labels, hasn't
30 it but I mean...

31 WALKER: Yes.

*Walker began working with
Peter in 1985*

marked w/ Peter since 1985 @ Whispering Pines 1988
number of plan before since 1992

1 HARRISON: ...the group that annually does his plan?
2 WALKER: This year will make fourteen years.
3 HARRISON: Okay. Are you familiar with the one on one services Peter now
4 receives and has received since before July 1, 1998?
5 WALKER: Yes.
6 HARRISON: Okay. Are you familiar with the service definitions that the
7 MRRD waiver services that are contained—and this is the brief
8 that I submitted today for the attorneys and for the hearing officer
9 that are contained between page 65 and 76, are you familiar with
10 these definitions?
11 WALKER: Yes, I am.
12 HARRISON: Okay. And are these all of the services that are provided under the
13 MRRD waiver?
14 HILL: Excuse me, is this page 65 of the attachments to your brief that you
15 submitted today?
16 HARRISON: The attachments today starting at 69, I'm sorry.
17 STREETER: That's appendix B, services and standards?
18 HARRISON: Uh-huh.
19 STREETER: Okay.
20 WALKER: And that's (unclear). This appears to be all the waiver services.
21 HARRISON: Okay. The service that Peter Brown is getting through his one on
22 one, the twelve hours of service, of these definitions in the waiver
23 contract, what best describes the service that Peter Brown is
24 getting?
25 WALKER: Well, it matches closely to adult companion services.
26 HARRISON: Okay. Are you prohibited by DDSN directives from including
27 adult companion services and plans of care?
28 WALKER: Yes, in the waiver manual which I have to go by as far as any
29 waiver service, there's specific guidelines for each waiver service
30 and procuring that or obtaining the information to justify the
31 service and in that waiver manual it does prohibit people that are

1 living in an SLP II from receiving that service. It's not eligible—
2 they're not eligible for that service.
3 HARRISON: Do you know anything other than this directive from DDSN, any
4 federal rule or any Medicaid rule that would prohibit a person from
5 receiving the service of adult companion service other than that in
6 the manual?
7 WALKER: Not that I'm aware of but I mean, you know, have privy to all of
8 the regulations but nothing that I'm aware of.
9 STREETER: Let me ask you something, Mrs. Harrison. Are you asking her
10 whether she is aware of any rule in Medicaid outside of the waiver
11 that prohibits the two services from going together, is that what
12 you're asking?
13 HARRISON: No, I'm asking if there's any, any rule outside of the DDSN
14 manual that pro—would prohibit this service that's included in the
15 waiver contract. Does she know of any federal rule that says she
16 can't...
17 STREETER: Okay, I just want to get clear on that. Thank you. Go ahead.
18 HARRISON: And I said I'm not aware of anything else but I may not be privy to
19 that information.
20 STREETER: Okay.
21 HARRISON: Okay. Do you have an opinion as a member of Peter Brown's
22 Circle of Support and his service coordinator as to whether the
23 twelve hours of one on one services that you just testified most
24 closely meet the definition of adult companion services in the
25 contract, are needed for the maximum reduction of physical or
26 mental disability and restoration to his best possible functional
27 level. Does he need these twelve hours?
28 WALKER: I mean I believe he does. And some of that goes back to where,
29 you know, understanding where Peter actually started from and
30 personal care aid is what he actually started out with and the actual
31 growth that I've seen, you know, occur with him over those years

1 so yeah, I would have to say my personal opinion I feel like they
2 are beneficial.

3 HARRISON: Based on your personal knowledge of Peter, do you believe that
4 Peter would regress socially if these services were terminated?

5 WALKER: I believe so.

6 HARRISON: Are you aware of the medical prescription for exercise due to his
7 condition of diabetes?

8 WALKER: Yes, I have those.

9 HARRISON: Do these services beneficially contribute to the need for exercise?

10 WALKER: Yes.

11 HARRISON: Do you think that—what, what change would we see in the amount
12 of exercise Peter gets if these services were taken away?

13 WALKER: It's hard to put an amount or a number with that. I don't know that
14 I could do that but I do feel like they would be reduced because he
15 would—he would not be as social.

16 HARRISON: Okay. Have you read the opinions of Dr. Reel and Dr. Collings
17 which for the attorneys are on page 80 of my first brief, based on—
18 have you read those doctor's opinions?

19 WALKER: Yes I have.

20 HARRISON: Okay, based on your personal knowledge of Peter Brown, do you
21 agree with the assessments of these doctors that Peter's physical
22 health would deteriorate if these one on one services were to be
23 discontinued?

24 WALKER: Yes.

25 HARRISON: DDSN has claimed that the one on one services in their brief,
26 DDSN has claimed that the one on one services are being provided
27 to Peter for the sole reason of placating Mrs. Brown, and I quote
28 that. Were you working with Peter when these services were first
29 put into place and is it true they were put into place solely to
30 placate Mrs. Brown?

31 STREETER: Keep it to one question at a time.

1 HARRISON: I'm sorry, were you involved when they were put into place?

2 WALKER: When I started as Peter's service coordinator in '91, I worked with

3 Patti directly for two years but even through the years I was

4 involved, either during the team meetings or the, uh, with the

5 service coordinator or I was filling in because I had a vacancy so

6 yes, I was involved.

7 HARRISON: Can you tell us how—did these one on one services, were they put

8 in place just to placate Mrs. Brown?

9 WALKER: No. In—at the time Peter was getting personal care aide services

10 and there was an audit that was done by Tanner Vanderbilt which

11 is a—was a DDSN lawyer, Janet Brock then—I believe Janet's

12 title was Medicaid coordinator and Reddick Lauren which was an

13 advocate with—all with the central office and I'm not sure why the

14 audit was—it was some misuse of funds or whatever but during

15 that audit from their findings and reviewing the services that Peter

16 were getting—was getting, they made the recommendation to

17 change the service from a personal care aide to enhanced staffing.

18 HARRISON: And when was that?

19 WALKER: They did the audit in February of 1996 and then the

20 recommendation came back in March of 1996 to Mr. Brumfield

21 who was the executive director.

22 HARRISON: Okay, is there a, a, category or a service—I'm sorry, is there a

23 Medicaid service in the MRRD waiver called enhanced staffing?

24 WALKER: Currently?

25 HARRISON: Right.

26 WALKER: No.

27 HARRISON: Has there been, can, can—has there been since 1997?

28 WALKER: I'm not really sure when that changed but I believe that at one of

29 the renewals for the waiver contract with HICFA and DDSN I

30 believe that was—there was some revisions and changes made but

31 I can't pinpoint when that actually occurred.

1 HARRISON: Okay. But, and when you say Janet Brock, is that Janet Brock
2 Priest?
3 WALKER: Yes.
4 HARRISON: That's the same person?
5 WALKER: Yes.
6 HARRISON: And are you saying that she recommended the enhanced waiver
7 services?
8 WALKER: Yes.
9 HARRISON: And when did Mrs. Priest recommend the enhanced waiver
10 services?
11 WALKER: In, uh, in the report that would have come to Mr. Brumfield in
12 March of 1996 in my notes they did the audit because they—I was
13 filling in as a service coordinator at that time and I was interviewed
14 and I had that in my notes and then the recommendation came
15 back.
16 HARRISON: The—I'm sorry, could I—could I have the exhibit, could I see the
17 exhibit that has the budget on there. I think she can enlighten some
18 on that.
19 STREETER: Are you talking about Exhibit 14 with five pages of budget
20 services?
21 HARRISON: That's it.
22 STREETER: There you go.
23 HARRISON: Okay, are you familiar with these documents?
24 WALKER: Yes I am.
25 HARRISON: How are you familiar with them? How do you know what they
26 are?
27 WALKER: Well, this is a part of the—what we call the waiver—MRRD
28 waiver budget that determines what services are authorized on the
29 waiver tracking system.
30 HARRISON: So all—are all of those waiver services?
31 WALKER: Yes.

1 HARRISON: So there's no services that aren't?

2 WALKER: No.

3 HARRISON: Contained in the waiver. Okay. From, from 1995 through June of

4 19—I'm sorry, 1990—no, you testified I believe that, that

5 previously the one on one, did you testify that the one on one was

6 personal care aide until 1996?

7 WALKER: Yes.

8 HARRISON: And then in 1996, was it billed differently?

9 WALKER: Yes.

10 HARRISON: Okay, how was it billed in 1996?

11 WALKER: Well, at the beginning of the year, the year being the July 1

12 through June 30, it would have been personal care aide at the time

13 it's showing here 3/14/96 would go to the end of June and then a

14 new budget would have to be resubmitted but enhanced staffing

15 residential started in 3/14/1996 according to this budget and was

16 approved at 225 hours.

17 HARRISON: Okay, I've looked through the waiver contract and I don't see a

18 service of enhanced—I'm sorry, intensive staffing residential. Is

19 there a service, a Medicaid waiver service called intensive staff

20 residential?

21 WALKER: No.

22 HARRISON: What service would that most closely resemble, intense staff

23 residential?

24 WALKER: Well, this would be adult companion—I mean it could be adult

25 companion, it could be, well, if it was personal care aide, it would

26 say personal care but it didn't, mainly adult companion.

27 HARRISON: Okay.

28 WALKER: Closely.

29 HARRISON: Now, but the agency billed for that service, is that correct?

30 WALKER: There was a what we, we call a monthly mon—uh, monthly

31 utilization form that was a part of the requirement to send that

1 information to DDSN that said this is how many hours of intensive
2 staffing or whatever the service was. In this case he took the
3 staffing, that Peter Brown received for this month.
4 HARRISON: Okay, and, and during the period '97, '98, '99, was there a service
5 that fits the definition of adult companion service that was being
6 billed to Medicaid?
7 WALKER: I'm not exactly sure how the Department, the DDSN state office
8 would have billed that to Medicaid or once it comes from the
9 Charles Lea Center on a monthly utilization, I don't really know
10 how the financial arrangement was made at that time but the
11 information came to DDSN cost analysis and then something was
12 done, I'm not—I can't testify to what was billed and how it was
13 handled at that point.
14 HARRISON: But Charles Lea Center billed for a service that most closely
15 resembles the definition of adult companion services, is that
16 correct?
17 WALKER: That's my understanding.
18 HARRISON: Okay. In the department's brief, they have stated that there was no
19 approval for this service, are these—tell me what these reports are.
20 WALKER: These are comments that are required whenever a waiver service is
21 requested through the waiver tracking system which is our
22 computerized way of communicating with each other through local
23 boards, regional boards and the state. So what's required when a
24 new service is requested is that you would go in and put the
25 information on—it would first show up on this scheduled service
26 record as pending, you know, you put the information in but to
27 support that you would have to go to another screen on the same
28 system and then write the comments in there with your justification
29 of why it's needed and, you know, have backup. Some things—
30 the service coordinator would—is responsible for that and then it
31 would go on to several other approval processes possibly. Some

1 things were able to be approved at the local board and some had to
2 go through the regional office and others would be approved at
3 central office level.
4 HARRISON: Okay. Who approved Peter's...
5 STREETER: I'm going to enter this as Petitioner's Exhibit 15, these two pages
6 of enhanced staffing reports, any objections?
7 LAWRENCE: None.
8 HARRISON: Who approved Peter's one on one service?
9 HILL: Exhibit 15?
10 STREETER: Yeah.
11 WALKER: The best that I know at that point would have been the regional
12 office.
13 HARRISON: Did you also have communications with the state office about
14 Peter's one on one service?
15 WALKER: Yes.
16 HARRISON: And tell me about the communications with the state office about
17 the one on one.
18 WALKER: When the recommendation was made, there was—there is a
19 internal directive that is called enhanced, um, I don't know the
20 official title but it's a form that's required to be filled out for an
21 enhanced staff request so that information about what the process
22 was, how do you obtain it, what are you required to keep, what
23 justification you have to have, what type of goals and objectives
24 may be approvable, that kind of thing.
25 HARRISON: So was there an assessment made to determine that Peter needed
26 these services?
27 WALKER: I can say there was at least an informal assessment and I would say
28 that possibly, you know, we would have gone back and looked at
29 what areas he was already trained in possibly with the personal
30 care aide but informal assessments can be done which would not
31 require extensive tools that, uh, but I think in this area we would

1 have to have the—some assessment type things that were based on,
2 some objectives to work with him.
3 HARRISON: Okay. So, could Mrs. Brown just say I want these services and,
4 and direct that they be provided if there was not an assessment that
5 he needed them?
6 WALKER: No. I mean there are various forms of requests and like I said
7 informal or formal assessments but it's, no, I mean there's no way
8 that you could, you could...
9 HARRISON: Were there goals and objectives related to this service?
10 WALKER: Yes.
11 HARRISON: Can you tell me about those?
12 WALKER: Can I see that?
13 HARRISON: This?
14 WALKER: In the request that was done for enhanced staffing, the residential
15 staff would have had to have submitted this form and on there...
16 HILL: Objection. Please identify what you're talking about or where
17 you're talking from.
18 STREETER: Identify it to me I think you mean.
19 WALKER: Oh, I'm sorry.
20 HILL: And to me as well.
21 STREETER: I have attachment B, South Carolina Disabilities and Special
22 Needs. I don't believe I have seen this before.
23 HILL: No, no.
24 STREETER: Where does this come from? Request for Continuation of
25 Enhanced Staff Report dated 6/22/99. Where does this—where
26 does this come from, Mrs. Harrison?
27 HARRISON: That comes from Peter's Charles Lea Center records.
28 STREETER: I don't believe I have this admitted into the record, do I?
29 HARRISON: I don't believe we do but we would like to admit it and I made
30 copies and I'm not able to put my hands on 'em. I'm sorry, I've
31 got flustered when I...

1 STREETER: Well, this copy must be your copy. It's got some notes on it. Do
2 you have objection to this copy being made and handed out to all
3 the parties?
4 HARRISON: I, I don't, I don't. Let me see, maybe—no, I don't have an
5 objection to that.
6 STREETER: Okay. Mr. Hill, if you would be so kind. We're going to go off
7 the record. If you could have copies made of this for everybody.
8 LAWRENCE: I'll do it. Tell me where to go.
9 STREETER: We're back on the record once again. We have Petitioner's
10 Exhibit Number 16 which is labeled South Carolina Department of
11 Disabilities and Special Needs Request for Continuation of
12 Enhanced Staff Services, Attachment B, and I've got two pages of
13 that and then I've got two more pages of Request for Continuation
14 of Enhanced Staff Services, all that's one exhibit, number 16. Go
15 ahead.
16 HARRISON: And I apologize for the mix-up. I...
17 STREETER: Not a problem. I think we're fine.
18 HARRISON: Mrs. Walker, did this authorize—the enhanced staff before? Is that
19 the same thing as one on one?
20 WALKER: Yes.
21 HARRISON: And is it the same thing as adult companion services? The
22 definition of adult companion services.
23 WALKER: The definitions are similar, yes.
24 HARRISON: Okay, and does this show that they were provided in '96, '97, '98,
25 and '99?
26 WALKER: Yes it does.
27 HARRISON: Okay, now there's a note down here at the bottom that says, do not
28 approve, will be included as a 15 hour permanent part time staff.
29 Tell me about that.
30 HILL: I apologize. Where are you reading from?
31 HARRISON: On the bottom of the front page.

1 STREETER: The notes on the first page.
2 HARRISON: Does that mean he didn't need one on one again, anymore?
3 WALKER: No, this...
4 HILL: Object, that hasn't been identified as who wrote that.
5 HARRISON: Okay, who wrote that?
6 WALKER: Elaine Bond.
7 HARRISON: Do you recognize her handwriting?
8 WALKER: Yes, E.B. is Elaine Bond and also she's listed on the second page.
9 HARRISON: And what was her position?
10 WALKER: Associate—Executive Director of Finance.
11 HARRISON: Okay, and tell me—she says do not approve, does that mean that
12 they're not approving the services of the one on one?
13 WALKER: No, at this time, it says it will be included as a fifteen hour
14 permanent part time staff at nine dollars an hour.
15 HARRISON: Was there—can you tell me what triggered that if you know?
16 STREETER: Well, I've got a question. I'd like this clarified for purposes of the
17 record. Who is it that wrote, this is how Bryan Flatten became
18 permanent part time staff today?
19 HARRISON: Those are my client's notes.
20 STREETER: Peter wrote that?
21 HARRISON: No, no, no, my guard—the guardian.
22 STREETER: Okay, so Mrs. Brown wrote that. Who wrote Bryan is not
23 classified an enhanced staff today?
24 HARRISON: Mrs. Brown.
25 STREETER: Okay. And who wrote out Elaine Bond down here in the right
26 hand corner?
27 HARRISON: Elaine Bond.
28 STREETER: I don't think so.
29 HARRISON: I'm sorry, I'm sorry. I thought you meant the note. No, Mrs.
30 Brown wrote with the arrow Elaine Bond.

1 STREETER: Okay, so Bryan's not classified as enhanced staff today has no part
2 of this original document nor is this is how Bryan Hatten became
3 permanent part time staff today, nor are the words spelled out
4 Elaine Bond, correct?

5 HARRISON: Right.

6 STREETER: Okay, go ahead.

7 HARRISON: Okay, does this mean that the one on one staff wasn't needed and
8 wasn't approved?

9 WALKER: No. The—I was a part of this approval process so it had to come
10 from the service coord—well, it came from the residential staff
11 originally Susan Mason and then it went to service coordinator. It
12 came to me as director of individual family support and everything
13 was fine. We checked out—we're checking to make sure the
14 justification's there and then at the point that it goes to finance
15 there was a change in—I don't know what the change was but
16 somehow Elaine changed it to be included as a fifteen hour
17 permanent part time staff but I also believe that this was around the
18 time that person-centered planning capitated funding, there was a
19 change in the way the boards were going to get paid through the
20 band pay as well. I'm not sure that's why it was done but I know
21 there was a difference in how many was handled or allocated.

22 HARRISON: But the timing of the change from enhanced staffing to permanent
23 part time staff coincided with that change.

24 WALKER: That's what I—that's what I remember, yes.

25 HARRISON: Can you tell me the difference between a service goal and an
26 objective, did I ask you that?

27 WALKER: Huh-uh.

28 STREETER: Not yet.

29 WALKER: I'm not the expert in this but I do know that I have to know enough
30 about it to be able to monitor residential habilitation, day
31 habilitation, anything—any service that a person's getting that is

1 goal oriented. And my understanding is your goal—a goal would
2 be where you want to—where you want to officially end up at
3 some point and you may have several objectives under that to help
4 you get to that goal.

5 HARRISON: Okay. If you have a service such as a one on one, might your
6 objective and your goal be time limited?

7 WALKER: Yes. They should be time limited.

8 HARRISON: Does that mean that you don't need the service anymore?

9 WALKER: No.

10 HARRISON: So, in the case of Peter Brown it was brought up that there was a
11 goal but it was stated that within three months he will participate
12 passively with this. Does that mean that he doesn't need the
13 service any more after those three months?

14 WALKER: No, not necessarily, no. That would be one objective.

15 STREETER: Let me see if I can help you here so we can move this along.
16 Okay, in your experience are goals often set at three and six month
17 period of times?

18 WALKER: Yes.

19 STREETER: Okay. Once a goal is achieved, is it usually expressed in a
20 percentage of correct responses or percentage of correct behaviors?

21 WALKER: Yes, but can I back up?

22 STREETER: Sure.

23 WALKER: When you said a goal, I would say an objective is written.

24 STREETER: Okay. An objective.

25 WALKER: To time limited, specific amount of time. Just like here, there's
26 a—I will participate in community activities for—with ninety
27 percent for three consecutive months. That would be an objective.

28 STREETER: Okay. Let's step away from the facts of this case for a minute.
29 Let's say my—the objective was for me to brush my teeth after
30 every meal and you want to monitor that over a three month period
31 of time with goals to help you reach the objective, okay? Now

1 once I reach that objective given the fact that I am moderately
2 retarded, mildly mentally retarded, am I going to maintain my
3 performance at that rate? In other words, if I get to eighty percent
4 for brushing my teeth after every meal, can you then quit?

5 WALKER: No.

6 STREETER: Okay, so am I going to be able to maintain eighty percent once I
7 reach it, without supervision in most cases?

8 WALKER: Some things you could and some things would probably need a
9 maintenance kind of goal that would require some prompting.

10 STREETER: So it depends on the activity whether it's achievable as a
11 permanent result or as a result that requires constant monitoring, is
12 that right?

13 WALKER: That's—I would agree with that.

14 STREETER: Okay, and when you're assessing services for someone, do you
15 want to monitor a whole range of activities or are you only going
16 to look at just a few?

17 WALKER: Well, it depends on the person you're working with. Some people
18 can only focus on a couple of things at once or one thing at a time.

19 STREETER: Okay.

20 WALKER: And so it would be confusing to have them on four or five different
21 objectives or goals but I guess you couldn't rule out—rule out that
22 that may work for some but I think it is more effective when you
23 have smaller steps to reach a goal and not as much going on.

24 STREETER: Okay. Go ahead.

25 HARRISON: Okay. This is a chart, are all of the activities or all the services,
26 I'm sorry, on the left hand side, are these all services contained in
27 the MRRD waiver?

28 WALKER: Yes, these are in the waiver.

29 HARRISON: Okay. And correct me if I'm wrong, this is my understanding
30 about the services you can offer to the various people at the various
31 places. If I'm wrong, please...

1 HILL: If I may object to the extent that this document does not indicate
2 on its face who prepared it, where it came from. Could that be
3 established before we move forward?
4 HARRISON: I prepared it and I'm asking her to verify or to change if there's
5 anything that needs changing and then if there's something that's
6 different, we'll hand out the one that she has...
7 HILL: Okay.
8 HARRISON: Is that satisfactory?
9 HILL: Yeah, uh-huh.
10 HARRISON: Okay. Is it true that the people at home are only offered the
11 services in that category? I'm sorry, in that column.
12 WALKER: Yes, the best of my recollection, they would be eligible if justified
13 for these services.
14 HARRISON: If they had an assessment of need?
15 WALKER: Need.
16 HARRISON: And then there would be goals established?
17 WALKER: Certain things have goals and objectives and others don't.
18 STREETER: But at the moment we're just talking about whether services are
19 possible for people in that category, is that correct?
20 HARRISON: Right.
21 STREETER: Okay, let's keep it to that if we can for right now.
22 HARRISON: Okay, I'm sorry. Okay, if you're in an SLP I, are these the two
23 services that can be included in a person's plan who lives in an
24 SLP I or are—if there are some others, please let us know and
25 we'll add those.
26 WALKER: Well, on this list if someone lived in an SLP I they would be
27 eligible for day habilitation...
28 HARRISON: Okay.
29 WALKER: ...or prevocational or support employment.
30 STREETER: They would be?
31 WALKER: They would be.

1 HARRISON: Okay.

2 WALKER: Personal care, I would have to look at that but I believe...

3 HARRISON: So we'll just put a question mark there.

4 WALKER: ... it could be but I would, you know, I would just have to read it.

5 Adult companion is. PTOC site behavior, nursing, I'd have to read

6 over the definitions again from the...

7 HARRISON: Are they—are those services now bundled in residential

8 habilitation?

9 WALKER: The way I understand the band payment is that it includes enhan—

10 what are considered enhanced waiver service—services and those

11 are take—pulled out of the band.

12 HARRISON: Okay, if you're in an SLP II, you can offer residential habilitation,

13 I mean obviously.

14 WALKER: Uh-huh.

15 HARRISON: Okay, what about day habilitation?

16 WALKER: Yes.

17 HARRISON: Okay, so we'll put a circle there. Okay, what about prevocational

18 services?

19 WALKER: Yes.

20 HARRISON: Okay, what about supported employment?

21 WALKER: Yes.

22 HARRISON: What about personal care?

23 WALKER: I'd have to read my definition. I'm not—I'm not sure, there's...

24 HARRISON: What about adult companion services?

25 WALKER: That is not allowed in my guidelines.

26 HARRISON: Okay. PTO II site services, behavioral supports and nursing, are

27 those included in residential habilitation or when you have that

28 budget report does it—can you have those services also or are

29 those bundled into residential habilitation?

30 WALKER: Not being in finance, I'm not exactly certain how the money is

31 received but I do know that the band payment includes...

1 STREETER: Fifteen minutes.

2 WALKER: ...enhanced services. Which ones, there may be some that are

3 pulled out of there that are billed for separately and I'm not certain.

4 HARRISON: In a CTH I, what services can you provide someone who's in a

5 CTH I?

6 WALKER: All...

7 HILL: I object to this. This is getting far a field. A CTH I is not in

8 question in this case.

9 HARRISON: Okay. I will withdraw that question. Okay...

10 STREETER: All right, let the record show I have the following changes made to

11 this document, SLP I, day habilitation is positive, I've so marked

12 it; prevocational services, I've so marked it; supported

13 employment services, so marked; for SLP II I've got day

14 habilitation, prevocational services, supported employment

15 services, is that correct?

16 WALKER: There are some others that they're eligible for, that one I

17 questioned and I just have to look at the...

18 STREETER: I don't want you to mark ones that are questionable. I just want

19 you to mark ones that, that you're certain that they can receive.

20 WALKER: PTO II, psyche and behavior on both.

21 STREETER: Okay. Anybody want a copy of this?

22 HILL: I do.

23 HARRISON: Do we need to wait, Jim?

24 HILL: No, go ahead.

25 HARRISON: Does Peter still have diabetes?

26 WALKER: Yes.

27 HARRISON: Is weight loss still a concern?

28 WALKER: Yes.

29 HARRISON: And how does the activity that Bryan Hatten does on Wednesday,

30 how might it be related to his weight?

31 WALKER: Well, at one point Peter was...

1 END OF SIDE 2, TAPE 3
2 BEGINNING OF SIDE 1, TAPE 4
3 (Inserted from P.96 above. BWS)
4 STREETER: All right, we're back on the record. You were saying Peter's on
5 Ensure.
6 WALKER: ~~He was on Ensure because he was losing weight and the menus—~~
7 he was not, he was on a pretty catchy diet and the menu—and he
8 wasn't always eating that amount so it just helps ensure that he is
9 getting the groceries he needs and actually following the menus
10 prepared by the dietician.
11 HARRISON: Okay. Do you feel that that service needs to be continued to
12 maintain his best possible function level?
13 WALKER: I think it does, yes.
14 HARRISON: What about the socialization? Do you think that that maximizes
15 ~~his functional level in any way?~~
16 WALKER: Certainly, I think—I mean I've seen the growth that Peter's had
17 over the years and the—I've also seen him when he's not had
18 someone to help him, stay in the bed until two o'clock. So yes, I
19 have to say it would benefit him.
20 STREETER: How does Bryan Hatten get him out of bed before two o'clock?
21 WALKER: They have their schedule and he's up and going. But, you know...
22 STREETER: Yeah, but how does Bryan Hatten get him out of bed before two
23 o'clock?
24 WALKER: Well, there's planned activities. There's things that he knows
25 he's...
26 STREETER: You mean on the weekend?
27 WALKER: Uh-huh.
28 STREETER: But not during the week.
29 WALKER: He works during the week and there's some things that he does
30 through other thing—Special Olympics or...

1 STREETER: Okay, all right. So you're primarily talking about getting him out
2 of the bed on the weekends. Okay, go ahead.

3 HARRISON: I think that's all we (unclear).

4 STREETER: Okay.
5 (The above section is also found at page 96 above, by error it was
6 taped over a part of Brian Hatten's testimony. BWS)

7 HARRISON: Exhibit 10.

8 STREETER: We're back on the record. Page 110 of the original brief.

9 HARRISON: Are you familiar with this document?

10 WALKER: Yes. It's been awhile since I've seen this but yes, I'm familiar
11 with this.

12 HARRISON: Can you tell me about it?

13 HILL: Before we talk about the document, can we ask the witness to
14 identify it?

15 HARRISON: Okay, would you identify the document.

16 WALKER: This is a letter written from Marilyn Horton who was—who is a
17 nutritionist or consultant dietician to Susan Mason and describing
18 Peter's diet and talks about the nine pounds of weight loss that
19 he'd experienced and the need for him to, you know, maintain his
20 menus, his caloric intake.

21 HARRISON: In your opinion, the twelve hours of services, does it help carry
22 out...

23 WALKER: I—yes (unclear).

24 HARRISON: Okay, I have one more thing to ask you about. This is Exhibit 11
25 in my initial brief, page 111, would you please read that and tell us
26 about that document.

27 WALKER: Read the whole thing?

28 HARRISON: I mean just read it to yourself.

29 STREETER: What document's this?

30 HARRISON: It's page 111 of my original brief.

1 STREETER: Let me see the document just for a minute here. All right, this is
2 memorandum to Al Brumfield from Jackie Walker, March 18,
3 1993. Go ahead.
4 WALKER: I had—I had been to Peter's apartment to do a site visit and he
5 had—the purpose was because he was getting a new personal care
6 aide and I was monitoring that. The aide didn't show up and it
7 indicates where I'm reporting to—I was the service coordinator at
8 the time, that I was reporting this to my boss and the executive
9 director of the things that were not being followed or monitored
10 and it goes on to describe which, you know, what things they were.
11 Not, um, mainly on his menus and the things that his aide, personal
12 care aide would have been working with him on and in the case
13 where they don't show up it's—it would have been the staff's
14 responsibility to follow-up and make sure that it was covered.
15 HARRISON: Did that happen, the follow-up?
16 WALKER: Well, in this when it says I asked Peter who helps him when his
17 personal care aide is not there he told me no one. And then I
18 informed the staff of the information.
19 HARRISON: Okay. Would you read the last sentence of that memorandum?
20 WALKER: I have a positive feeling that Peter will eventually be able to follow
21 a routine but only with intensive and continuous training in these
22 areas.
23 HARRISON: We are twelve years out and do you see any difference in his need
24 for the intensive and continuing training in these areas?
25 WALKER: The training has changed over the years. There's still needs that
26 Peter has and, and, thankfully I've been a part of being able to see
27 where he started and where he's progressed to so, you know,
28 you're not going to be on the same, hopefully, you're not going to
29 be on the same objective for twelve years. But yes, I still—I still
30 agree that this is how Peter Brown learns.
31 HARRISON: Do you see him graduating from the need for these services?

1 WALKER: It's hard to say and I would not want to limit anyone but I think
2 they're always things that Peter, you know, will need to receive
3 training on or help with.
4 HARRISON: Okay, thank you very much.
5 STREETER: All right, Mr. Hill.
6 HILL: Thank you. Mrs. Walker, if you don't mind, I'm going to be
7 somewhat eclectic and jump around because this is kind of unique
8 to, to talk to you about some of these things. Let me get on to this
9 last issue. Apparently in '93, you wrote this memorandum to Al
10 Brumfield and that you have a positive feeling as the Appellant's
11 attorney mentioned in the last sentence that eventually he'll have—
12 be able to follow a routine. And that was what, twelve years ago
13 when you wrote that, okay, and between then and now he's had the
14 same twelve hours of enhanced services, correct?
15 WALKER: At that point, he had personal care aide services.
16 HILL: Is there a difference?
17 WALKER: Yeah.
18 HILL: What is the difference?
19 WALKER: Personal care aide is through—I mean we were hiring someone
20 through like an interim health care provider of that service, outside
21 of Charles Lea. It wasn't staff and those—not always but
22 mainly—some of those people are like nursing assistant type
23 trained, trained. The service was initially started with what I
24 remember was Peter had, uh, had pre-diabetic conditions and his
25 diet was very important so in the beginning the aide was doing,
26 you know, they're allowed to do things actually for them and it's
27 not as directed toward training. You don't have that, you know,
28 requirement in there so it was...
29 HILL: Pretty much initially started off with a diet issue because he was
30 losing weight or something and early on it was determined to be
31 hypoglycemic, I believe. Later I think someone said that he's now

1 been classified or diagnosed as having diabetes. So the diet thing
2 is—was very important initially and the PCA which started this
3 thing off was primarily there to monitor his diet?
4 WALKER: Well, there were different stages in it. I mean in the very
5 beginning the waiver was brand new too.
6 HILL: Uh-huh.
7 WALKER: Because this was like a couple of months after the waiver even
8 started.
9 HILL: Uh-huh.
10 WALKER: So some of the things that we were asking for were, you know, a
11 lot of other people were getting those services too at the SLP II.
12 HILL: Uh-huh.
13 WALKER: Just to enhance their self-help household cleaning kind of things.
14 HILL: So we started off with PCA primarily monitorship of the diet,
15 right?
16 WALKER: That was the big focus.
17 HILL: Over the years this thing has evolved now to what it is today, is
18 that correct?
19 WALKER: Yes.
20 HILL: Okay. Now, that's a good point. Getting back to this exhibit that
21 you just spoke of on the last sentence there, positive feelings that
22 eventually he'll be able to follow some routine, some twelve years
23 ago. With this enhanced service he hasn't attained, apparently,
24 where he needs to be, is that correct?
25 WALKER: Well, he's, he, he's moved on. I mean, we're no longer having a
26 personal care aide to feed him his meals.
27 HILL: So that has evolved now into leisure activities.
28 WALKER: Well, and there's still parts of the, um, what do you call it, meal,
29 grocery shopping lists.
30 HILL: Yeah, yeah. What is so unique about Peter that he requires a
31 special one on one person to assist him in leisure activities where

1 I've heard through testimony here that no one else in that particular
2 SLP II program has those unique needs?
3 HARRISON: Objection. We're not here to discuss the needs of other...
4 HILL: I've asked about Peter.
5 STREETER: He's asking about Peter's needs and I think we've had testimony
6 that Peter's the most exemplary person in that facility so I think it's
7 a fair question. Go ahead.
8 HILL: Please, answer the question, Mrs. Walker.
9 WALKER: Well, I think that over the—I mean you know and I'm going
10 back...
11 HILL: Uh-huh.
12 WALKER: ...you know sometimes where Peter started from and where he is
13 now, it seems like it's so long ago sometimes but Peter's needs
14 with vulnerability and pleasing, and...
15 HILL: His what? His needs...
16 STREETER: Vulnerability and pleasing.
17 HILL: Vulnerability.
18 WALKER: And pleasing were a lot, I mean, how some of this originated as
19 well as his health problems. And I still believe to this day that if
20 you had some, some, uh, the right kind of person coaxing him that
21 he's just gonna be that trusting. So I don't see that in a lot of the
22 other people that I know that are there.
23 LAWRENCE: If he had the right kind of person coaxing him, he would be that
24 trusting.
25 STREETER: I think we're talking about evil companions.
26 WALKER: Like vulnerable. I, I...
27 HILL: Does Peter have a history of associating with evil companions?
28 STREETER: Go ahead and answer.
29 WALKER: I think he's been protected to where he wouldn't have that
30 opportunity. There was a report of a staff person years ago...

1 HILL: Staff person? How would an enhanced person keep him protected
2 from a staff person?

3 WALKER: Well....

4 HILL: It's kind of an inside job, if you want—to be crude about it, you
5 know.

6 WALKER: I guess the other side of it is we don't want him to have
7 experienced that either so I think that it's a part of our protection.

8 STREETER: Let me interrupt you. I think this is a fair question, okay? And
9 I'm going to hypothesize here. Okay? And my hypothetical is not
10 to be taken by anyone as casting aspersions upon their facility or
11 plan but if you had someone who was not pure of purpose who is
12 on the staff, let's say, who might lead Peter astray, how would
13 having the services of a one on one as Peter has now protect him
14 from that? Or would it?

15 WALKER: Well, it, it probably wouldn't have an effect in that area.

16 STREETER: Can we move on from that now?

17 HILL: Mrs. Walker, there's been some testimony here that Mrs. Brown
18 objected to Peter going into an SLP II when he was moved from an
19 ICF. You've known Peter for a number of years, do you think that
20 Peter is really an SLP II client category type person or would he be
21 better off in a say, a CTH II or even a CTH I for that matter? For
22 his services and his needs, being the vulnerable person that you say
23 he is.

24 WALKER: Well, I didn't know Peter when he came from the ICF. I met him
25 after he already moved into the SLP II. But I think that a part of
26 where person-centered and supports from the waiver come in are
27 that we—we want to provide people with the least restrictive
28 setting we can with the supports they need to make it.

29 HILL: That's good philosophy. But talk about Peter.

30 WALKER: That's what I'm saying about Peter. I think that—I think with the
31 proper supports, Peter has done well where he is.

1 HILL: Okay. So the proper supports really are unique to Peter for these
2 twelve hours. Would that be an outlier under the waiver program,
3 what he need an outlier so he can get special funding for these
4 twelve...

5 STREETER: What's an outlier?

6 HILL: An outlier, sir, is an additional fee from the Department for certain
7 services that have been assessed as needed, that otherwise would
8 not be provided for under the service that is currently being
9 provided. For example, if Peter needed a service beyond what
10 residential habilitation would pay for and it was identified as
11 assessed, am I not correct, Mrs. Walker?

12 HARRISON: Ob...

13 HILL: Do you know what an outlier is?

14 WALKER: I know.

15 STREETER: What are you trying to object to now, Mrs. Harrison?

16 HARRISON: If we're going to get into a discussion about the financial issues,
17 the band payment is an average and whether or not Peter needs
18 outlier funding, I don't think this witness is the appropriate person
19 to testify about that. We've filed briefs on...

20 STREETER: If anybody's opened the door to financial questions, it's you.

21 HARRISON: Okay.

22 STREETER: Okay? So, you opened the door for that. I would say, Mr. Hill, that
23 I would like to see you confine it to something related to the issues
24 that I've got at hand but if you do understand what an outlying
25 service is? Okay. I'm not sure I grasp the extent of this question
26 so I'm going to let you go ahead but you're probably going to have
27 to explain your answer to me in a minute. Go ahead.

28 HILL: As service coordinator chosen by Peter's guardian, you are the, uh,
29 uh, what is the term in the—in the single's plan, the, the, primary
30 person to develop the plan? Isn't that what you...

31 WALKER: Plan manager.

1 HILL: Plan manager, that's what I'm looking for. You are the plan
2 manager so if there's any thought development or request for any
3 service whatsoever it would have to come to you and because
4 you're qualified as a service coordinator, you know these things.
5 WALKER: Yes and no. Yes, it is up to me to find the avenues.
6 HILL: Uh-huh. And the funding sources.
7 WALKER: Well, not always. If, if someone moves in a residential setting, and
8 let's say SLP II at this point, and I'm going on information, they're
9 a lot—I mean, I'm not the expert in this area, but there are ways
10 that the Charles Lea Center residential program could request a
11 different band level payment.
12 HILL: But that would have to come through the single plan and you
13 would have to be on top of that as the plan manager. They just
14 couldn't ask for it themselves. It has to come through the plan.
15 Am I not correct? It would have to come through your review.
16 WALKER: It would have to be a part of the plan. You couldn't just show that
17 someone had needs.
18 HILL: So, you, you would be on top of it.
19 STREETER: Let me interrupt so I can understand in plain English. It's, it's—
20 and correct me if I'm wrong because I don't want to put words in
21 your mouth, I'm just trying to express whether I have an
22 understanding of this. You, you, you've got a band, payment band
23 for services under the waiver and if someone needed services that
24 weren't covered by that and there was an established need for
25 those services you might do this outlier sort of thing to get funding
26 for that special service or you might go to a different band, is that
27 what you're telling me?
28 WALKER: Yes.
29 STREETER: You could do either one of those two things.
30 WALKER: That's my understanding.
31 STREETER: Okay. All right, thank you.

1 HILL: This exhibit, Appellant Exhibit 16, down here apparently has
2 Elaine Bond's writing at the bottom, you saw that.

3 WALKER: Yes.

4 HILL: There was a request for enhanced staff support. That was put on—
5 a negative on that or a nix on that by Mrs. Bond apparently. Is that
6 what your testimony is?

7 WALKER: Yes.

8 HILL: All right and in the stead, a permanent employee, albeit part time
9 was hired.

10 WALKER: Yes.

11 HILL: Bryan Hatten in this—in this case.

12 WALKER: I'm not sure that he was the worker at that...

13 HILL: At that time.

14 WALKER: There was a...

15 HILL: Okay, and that's—so at this point in time, June 30 of '99, we're
16 past the personal care aide and now we're into the enhanced staff
17 person which funding for that has been disapproved by Charles
18 Lea Center but in the stead, they've hired a person for—to, and
19 dedicated that person's time to Peter. That's what that says.
20 Correct?

21 WALKER: Yes.

22 HILL: Okay. Now, I note here that there was reference to—well, let me
23 back up. Are you aware of any assessments that have been made
24 by any professionals that would support the, the—from the request
25 here even and back in '99 for enhanced staffing?

26 WALKER: Well, the residential staff in this case would have had to have done
27 assessments to pull out their objectives.

28 HILL: Okay, now you worked with Peter for fourteen years. Can you
29 show me an assessment for enhanced staff that has identified
30 Peter's need for this particular twelve hours enhanced staffing, an
31 assessment?

1 WALKER: I wouldn't do the assessments and I wouldn't have the
2 assessments.
3 HILL: But you're the plan manager and if they—if twelve hours went on
4 the plan you'd have to put it there based on an assessment because
5 you just couldn't add services without an assessment.
6 WALKER: Right.
7 HILL: Okay.
8 WALKER: But when I do the plan or there's a change, there's several ways
9 that if you're doing the annual plan and it's a part of the
10 assessment, that gets reported in a prestaffing report from the
11 QMRP.
12 STREETER: Let me interrupt. So you'd use the prestaffing report in preparing
13 your documents?
14 WALKER: Yes, when it comes to that piece of the pie.
15 STREETER: All right.
16 HILL: Okay. Now, are you aware of that the prestaffing support for say
17 2003, are you aware of that? Do you know it's—I'm sorry 2004.
18 WALKER: Uh-huh, yes, I mean...
19 HILL: I mean you're aware of Peter's plans. All right. Is there, to your
20 knowledge, any assessment that you can point to that gives the
21 basis for this twelve hours enhanced services?
22 WALKER: Okay, in—on the—it's not numbered but on 1, 2, 3, the 5th page.
23 HILL: You're looking at the 5th page of 2004.
24 WALKER: Plan.
25 HILL: Uh-huh.
26 WALKER: The information that's sent to me about assessments is about half
27 way down. Peter has been assessed using the Charles Lea Center
28 taxonomy. The DDSN SLP assessment that—you see where I am?
29 HILL: Uh-huh.
30 WALKER: Okay, when it gets reported to me I get the names of the
31 assessment—the assessments that have been done and as a result of

1 that assessment, if you continue on to the next page at the bottom,
2 the QMRP would recommend from these assessments, these are
3 the specific training objectives I recommend for the following
4 year.

5 HILL: Okay, let me look at that. Look on page 5 where you just read. It
6 says Peter has been assessed by the CLC taxonomy and then it
7 goes down and says Peter is independent with self-help—self-care
8 skills. No assistance is needed. What is self-care skills?

9 WALKER: Well, bathing, brushing your teeth, washing your hair, I mean, self.

10 HILL: Okay. He is verbal and able to make his wants and needs known.

11 WALKER: Uh-huh.

12 HILL: Peter continues on training needs in the areas of independent living
13 and community living. Has there been any identification what
14 community living is or independent living is. What is
15 independent—those are kind of broad categories. What does that
16 mean? Is that defined in the plan anywhere?

17 WALKER: Well, this...

18 HARRISON: What page are you on?

19 HILL: I'm on page 5 of the 2004 plan.

20 WALKER: This assess—this is—this is the prestaffing information I'm telling
21 you about.

22 HILL: Right.

23 WALKER: So I didn't actually write that part.

24 HILL: But that comes to you, that comes to you.

25 WALKER: Yes.

26 HILL: Right.

27 WALKER: But the, uh, where he continues to work on that... Peter has a goal
28 or objective, you know, in the ones that are above that. They're
29 listed starting on the previous page, bottom. It says these are the
30 current...

31 HILL: All right.

1 STREETER: Is it Peter's working on the following training objectives...

2 WALKER: Yes.

3 STREETER: ...is that what you're talking about?

4 HILL: Planning for weekend activities? Peter is currently receiving 33

5 percent independence training?

6 WALKER: Yes. That right there. No, I'm—okay, you're at the top.

7 HILL: On page 5. I'm looking—where are you looking at?

8 WALKER: Well, it starts on the bottom of the previous page.

9 STREETER: On 4, bottom of 4.

10 HILL: Right, uh-huh.

11 STREETER: Cleaning baseboards and laundering bathrooms, yes. And then the

12 next one is cleaning the refrigerator.

13 WALKER: Yes.

14 STREETER: Then it moves on to page 5 with use of appliances.

15 HILL: Okay. What I see (unclear) up here for weekend activities, Peter is

16 currently at 33 percent independence on his training. Where does

17 that come from?

18 WALKER: The QMRP.

19 HILL: What is the QMRP and who—that's Susan Mason, right?

20 WALKER: Yes.

21 HILL: Where does she get that information?

22 WALKER: Well, her staff keep—her staff that do the training keep data sheets

23 that record the training that's done on the specific day that it's

24 performed and whether or not he...

25 HILL: Okay.

26 WALKER: ...accomplished it or not.

27 STREETER: And Susan Mason works for who?

28 WALKER: Charles Lea.

29 HILL: Charles Lea.

30 STREETER: Okay, go ahead.

1 HILL: But I understand that nobody from Charles Lea works with Peter
2 on these activities. That it's solely Bryan Hatten, is that correct?
3 WALKER: Well, if, if, uh, Mr. Hatten's not there then the staff has to...
4 HILL: But, but, he's full time, I mean he's permanent part time so he's
5 there most of the time I would assume. It's been testified he comes
6 in on Wednesdays, Friday—Saturday and Sunday, right? Are you
7 saying he's not there most of the time?
8 WALKER: Well, twelve hours would not be most of the time.
9 HILL: All right. Get what I'm saying now. This information, 33 percent
10 comes from Susan Mason. Susan Mason and CLC does not work
11 with Peter on his leisure time activities, that's been...
12 HARRISON: Objection, we've had testimony that Bryan Hatten is a CLC
13 employee.
14 HILL: What, what?
15 STREETER: Is Bryan Hatten a part time employee?
16 HARRISON: Yes.
17 HILL: All right, all right. Okay, I see your point. Susan Mason gets her
18 information not from anyone else but from Bryan Hatten on this
19 topic.
20 WALKER: No, there would be—there would be other—there are other
21 objectives.
22 HILL: I mean...
23 STREETER: No, no, just this one.
24 WALKER: Oh, I'm not—I don't know that I can answer that.
25 HILL: Well, you're the plan manager. You have to know this sort of
26 stuff, do you not, to certify this is a decent plan that we're paying
27 money for?
28 WALKER: Yes, I would certify the accuracy of the information...
29 HILL: I'm not...
30 WALKER: ...but I mean I'm more interested in the fact if he's making no
31 progress, if he is regressing...

1 HILL: Well, let me, let me trace this through since I'm on cross. I have a
2 little more lead way here. You're the plan manager, I take it and
3 you've testified that you've had—supposed to know everything
4 pretty much in how this thing is developed. We know that Bryan
5 at this point in time, 2000—well, this plan year 2005 is getting
6 twelve hours enhanced services from Bryan Hatten and that
7 includes planning for weekend activities. And according to this
8 report here that apparently is submitted by Susan Mason, QMRP,
9 that he's getting up to 33 percent independent training or he is at
10 33 percent independent in training. Is it not true then, based on
11 your knowledge, that that information can only come from Bryan
12 Hatten since he's the only one that's working with Peter on this
13 issue?

14 WALKER: I don't know that. I don't...

15 HILL: Are there other people working with Bry—with Peter beside Bryan
16 Hatten in this area?

17 WALKER: I assume—there's no way that I know that for certain.

18 HILL: I'm sorry I'm incredulous because this whole—this whole
19 argument is about the twelve hours Bryan Hatten is providing to
20 Peter for community activities and meal prepara—or meal
21 monitorship or something.

22 WALKER: But it also, uh, staff are out. There are other things that may
23 happen.

24 HILL: Well, that's pretty rare because Bryan is identified with Peter
25 specifically and you're the plan manager. You know this, you
26 wrote the plan.

27 WALKER: But I don't supervise Bryan Hatten.

28 HILL: No, but I'm—is it not true that...

29 STREETER: All right, I think she's answered that she does not know...

30 HILL: All right.

1 HARRISON: Objection.

2 HILL: What grounds?

3 STREETER: Why? Oh, let me ask that.

4 HILL: I'm sorry.

5 HARRISON: I'm sorry. I'll—he can ask that question, I'm sorry.

6 STREETER: Okay, go ahead. Back to your question now. Start over for me.

7 I'm old.

8 HILL: Me too. Is it, is it true that the only waiver service that Peter is
9 currently receiving is residential habilitation?

10 WALKER: Peter is receiving residential habilitation and adult dental services.
11 HILL: Adult dental and visual.

12 WALKER: Well...

13 HILL: And pharmaceutical and service coordination. But the waiver...

14 WALKER: The waiver service residential and adult dental. Service
15 coordination is not a waiver service. The vision is not a waiver
16 service.

17 HILL: Okay, I stand corrected. I appreciate that.

18 STREETER: Okay, so let me make—I don't understand. Adult dental and
19 visual and pharmaceutical are not waived services, is that
20 correct?

21 WALKER: Adult dental is a waived service.

22 STREETER: Okay, dental is. Okay.

23 WALKER: Vision is Medicaid but it's state Medicaid and unless he would
24 need glasses, which he doesn't.

25 STREETER: Well, anyone under the waiver has a Medicaid card too so they get
26 Medicaid services outside the waiver. Okay. Got that. Go ahead.

27 HILL: Right. And he does not get adult companion. I think as an SLP II
28 resident, he cannot under the waiver manual get...

29 WALKER: Not according to my guidelines, true.

1 HILL: Okay. You said that on direct that some of this enhanced services
2 are similar to adult companion type services and you can get those
3 services if you were in a CTH, I or II.

4 STREETER: You can get what services?

5 HILL: Adult Companion.

6 STREETER: Okay, but you're saying...

7 HILL: As, as, as, ment—as, as, as dotted here. I think that's, well, we
8 didn't get over to the CTH's because that was irrelevant but I mean
9 he cannot get adult companion at this point in time at his present
10 residential.

11 WALKER: That's true.

12 HILL: Okay. All right. Now I believe that back in '98 he was under a
13 very limited goal, if you will, of enhanced services that ended after
14 three months. Were you aware of that?

15 WALKER: I don't recall that. I'm not—I may if I saw it but I wouldn't have
16 been the direct coordinator at the time.

17 HILL: Okay. Susan Mason I believe was still QMRP at that time. The—
18 at that time that's when we changed over to person-centered
19 planning in '98, July of '98.

20 WALKER: I think so. I mean I'm not for sure.

21 HILL: Okay. To your knowledge, has Peter received any enhanced
22 services after July of '98?

23 WALKER: Yes.

24 HILL: Yes?

25 WALKER: Yes.

26 HILL: Now what is the purpose of the plan, single plan? That is, that is
27 required by Medicaid in the waiver?

28 WALKER: Yes, it's required but it's also a means to provide the person that
29 you're working with with the supports they need and to get them
30 from one place to another.

1 HILL: Uh-huh. These goals and objectives you're talking about. That's
2 how it laid out. Now the plan is only good for 365 days, is that
3 correct? And if you don't have a plan, you cannot get funding, is
4 that correct?

5 WALKER: That's true.

6 HILL: All right. Now, and I'm speeding through this because we're time
7 limited here, so bear with me. In the plan, the development of the
8 plan, you have the background document or prestaffing report that
9 comes out, gives you what the staff tell you as service coordinator.

10 WALKER: Right.

11 HILL: Okay. Peter then can meet with you. You're the plan maker or
12 plan manager and you're required to be at the team meeting
13 whenever the plan is developed because you are a required
14 participant as well as Peter.

15 WALKER: I have to be there. Mrs. Brown has to be there.

16 HILL: All right, Mrs. Brown has to be there because she's guardian and
17 he's an adult, okay, so she's there. Now under the program he has
18 a right to ask for some friends, what we call a Circle of Support
19 come in.

20 WALKER: True.

21 HILL: All right, what do they do?

22 WALKER: Well, they participate in his plan. I mean...

23 HILL: How do they participate?

24 WALKER: Well, when, when the prestaff—when the background document is
25 done...

26 HILL: Uh-huh.

27 WALKER: It's completed prior to the meeting and some of the—some of the
28 things that are on there are needs that he currently has or needs that
29 may be coming up that we already know about so that's like a part
30 A, that's A section. So we review those needs and then at the plan
31 we determine if there are other needs or if there are things that are

1 on the pre—the background document that the person doesn't
2 agree with such as, you know, I don't want to train on this. I want
3 to train on something else. Then all of that's discussed at that
4 point. There are, hopefully, creative inputs—input from other
5 members of the team to see how we can best accomplish what the
6 person needs.

7 HILL: Are you familiar with this document, the so-called Blue Book
8 which has been presented by the Appellant in one of her briefs?

9 WALKER: Yes, I've seen that.

10 HILL: Okay, it's handed out to all the families—is that—available to the
11 families?

12 WALKER: I believe so, yes sir.

13 HILL: It's pretty standard. It talks about the Circle of Support. It talks
14 about the Circle being a group of usually family, friends or co-
15 workers, neighbors, church members or service coordinators or
16 even staff members.

17 WALKER: Uh-huh.

18 HILL: And they agree to meet on a regular basis. To assist the individual,
19 Peter, and helping Peter, or persons like him, decide what their
20 goals and desires and dreams and wishes and all that sort of stuff
21 are, is that right? Help him to see where he is with his talents or
22 his deficits or his skills and help guide him, if you will, toward a
23 realistic plan, is that correct?

24 WALKER: Yes.

25 HILL: Okay. Does the Circle of Support have authority to dictate what
26 services Peter will receive?

27 WALKER: I'm not sure of that. I can't—I mean that's a loaded question.

28 HILL: No, it's not loaded. It's just...

29 STREETER: Don't argue about the question. Try to give him an answer first.

30 WALKER: The plan guides—my understanding is the plan guides the service
31 so to say that there's any one person that dictates what someone

1 receives I would say no to that so I would have to say yes, the team
2 would have input into the plan but not necessarily any one's input.
3 HILL: They help Peter make his choices, am I correct? Say yes or no.
4 WALKER: Yes.
5 HILL: Okay. Now, you are familiar with the 2003 plan and the reason
6 I'm going over the 2004 plan and 2003 plan, the 2004 plan is still
7 in effect today, correct?
8 WALKER: The 2000...
9 HILL: 4 plan.
10 WALKER: 4 plan is in effect.
11 HILL: All right, so the previous plan would be the 2003 plan. Okay.
12 Most of the stuff that you referred to really happened back in the
13 nineties. I'd like to move it up to 2003-2004.
14 STREETER: Let's move it up pretty quickly.
15 HILL: Okay. In the 2003 plan, are you aware that in the current life
16 situation, what is the—the single plan I think is 2003, 10/29/2003
17 on page 4. See on page 4? Says there participate in community
18 activities?
19 STREETER: And that's 2003 or 2004?
20 HILL: That's 2003, sir.
21 STREETER: Okay, page 4.
22 HILL: Page 4, 2003. It says participation—participating in community
23 activities. Peter met the criteria for this training objective in March
24 of '03. So the taxonomy or the people telling you how he's done,
25 they say that he's met community activities in March of '03. Is
26 that correct, is that what that means?
27 WALKER: Yes.
28 HILL: Okay, now again, and you can compare 2003 with 2004. Again,
29 the only service, Medicaid service, other than adult dental that has
30 been recommended is residential habilitation and that's on the
31 pre—preceding pages there. Okay.

1 WALKER: Yes.

2 HILL: All right, is there any assessment that is referred to or any specific
3 identification that in the plan of service that Bryan Hatten or an
4 enhanced staff person will help Peter with community participation
5 or home care skills?

6 STREETER: In 2004?

7 HILL: 2003 or 2004. You can use either of those plans.

8 WALKER: Assessment, I mean it talks about, um...

9 HILL: Well, in 2003 it said he met his community activity so...

10 WALKER: But he's also working on planning act—or, uh, yeah, planning
11 activities and emergency procedures within the community,
12 learning emergency procedures for the specific arena.

13 HILL: Is there any indication in there that he is to have a specific twelve
14 hours, as a plan of support, twelve hours of enhanced services?
15 Because you move from background documents to the plan of
16 service to the plan of support, right? Or what is that middle one?

17 WALKER: Well, the—yes, it's—yes, I understand what you're saying.

18 HILL: Okay, the planning document and then the plan of support. And
19 the plan of support is what you work for in the coming year.

20 WALKER: But Bryan is a residential habilitation staff person so there's not a
21 need that is—that is separated from residential—residential
22 habilitation.

23 HILL: Okay, how many residential habilitation staff people does Charles
24 Lea Center have, do you know?

25 WALKER: I don't know.

26 HILL: More than just one?

27 WALKER: Oh yes.

28 HILL: Okay.

29 STREETER: So what you're telling me is Bryan is actually an employee and so
30 therefore he's providing residential habilitation services, yes or no?

31 WALKER: Well, in 1999 when he became a permanent part time employee...

1 STREETER: We're talking 2003-2004.

2 WALKER: But that's all I know from when they changed the enhanced
3 staffing to the permanent part time.

4 STREETER: Yeah, but you just said he's a—you just emphasized he's a
5 residential habilitation staff member. You did that, just now.

6 WALKER: He's a part time—permanent part time staff.

7 STREETER: So are you telling me that as far as the plan is concerned—and I'm
8 asking you because you're the one who drafted the plan, okay, as
9 far as the plan is concerned, this services and this identified need
10 and this training for integration into society, socialization services
11 and the meal planning and all that, are you telling me that's under
12 the umbrella of residential habilitation or that's something else
13 again?

14 WALKER: Well, I'm saying according to the way that we have classified
15 things over the years...

16 STREETER: Uh-huh.

17 WALKER: ...through the PCA, the enhanced staffing and the way this was
18 wrote into the budget there was no other...

19 STREETER: Category?

20 WALKER: ...category to put it in.

21 STREETER: All right, go ahead, Mr. Hill but make it real brief.

22 HILL: How about I'm finished.

23 STREETER: Okay.

24 HILL: Thank you sir.

25 STREETER: All right, well, I have a couple of questions. Are you familiar,
26 Mrs. Walker, with the waiver itself? The actual waiver
27 document...

28 WALKER: Document...

29 STREETER: ...it says it's a contract between the state Medicaid agency and the
30 federal government as to what the waiver is and what it supplies.

1 WALKER: Yes. Well, expert, I would—I mean it's been awhile since I read it
2 but yes, I do know.

3 STREETER: Okay, I have a copy here which is Respondent's Exhibit 38 and I'll
4 be glad to show it to you but I'm gonna read this. Number 2 says
5 this waiver is requested in order to provide a home and community
6 based services to individuals who but for the provision of such
7 services would require the following levels of care the cost of
8 which could be reimbursed under the approved Medicaid state plan
9 and under that is checked intermediate care facility for mentally
10 retarded persons with related disabilities. Now you've testified
11 that you've worked with Peter for some years and that you did
12 have something to do with putting the plans together so my
13 question is, based on this plan and I don't—I'm not real interested
14 in splitting hairs as to what category the services are under the
15 plan, we have Bryan Hatten giving him some support in terms of
16 getting his menu together, putting his shopping list together and
17 getting the appropriate supplies to follow his menu for the next
18 week and we have Bryan Hatten helping him plan weekend
19 activities that involve some socialization skills and also include as
20 a subset some safety issues, okay?

21 END OF SIDE 1, TAPE 4

22 BEGINNING OF SIDE 2, TAPE 4

23 STREETER: All right, we're back. Having heard that, can you tell me how any
24 of those particular services that Bryan Hatten as to one on one is
25 providing, how they keep Peter from going into an intermediate
26 care facility for the mentally retarded or going back into one?

27 WALKER: Well, it helps him to, I mean one of the things that it's the most
28 important for is to keep him from regressing. I mean, he's—to get
29 someone to their optimal function...

30 STREETER: Uh-huh.

1 WALKER: I mean for him to have come from an ICF and progress to the point
2 he is now. I don't think there's any question of how it's helped him
3 to retain that and to continue in the community.

4 STREETER: Okay. We've heard a lot about Peter's level of function so I want
5 to make sure I'm clear on this. As service coordinator, have you
6 had any opportunity over the years, you've been working with him
7 for twelve years, to see the results of any formalized psychological
8 testing that was done on Peter?

9 WALKER: Have I seen his psychologicals?

10 STREETER: Yes.

11 WALKER: Yes, they're—some are old.

12 STREETER: Okay, are you familiar with how mental retardation is generally
13 classified. Okay. This is called the Merck Manual and this is just
14 a physician's handbook. Are you familiar with this as a reference
15 book? All right and it has provisions for mental retardation and it
16 talks about the various levels of mental retardation. Do you use the
17 Merck Manual classifications for mental retardation when you're
18 deciding how retarded a person is?

19 WALKER: I don't, but the Department or the person that's doing eligibility
20 would determine that.

21 STREETER: All right, do you—do you understand in the course of your work
22 what the difference is between profound—or differences are
23 between profound, severe, moderate and mild mental retardation?

24 WALKER: Specifically, I mean I know what those levels entail but I mean to
25 define them, no, I...

26 STREETER: I'm not asking you for I.Q. scores.

27 WALKER: Yeah.

28 STREETER: Because we're talking different instruments, different test
29 instruments have different scores and there are valid and invalid
30 instruments for various things. There are instruments that test
31 people in the normal range quite well but don't do well with people

1 LAWRENCE: We're talking about the status quo as to the act—activities, two
2 activities per week, the non-disabled children as had been—non-
3 disabled persons as had been operating.
4 STREETER: Yeah, we're talking about the menu plan and the, the, actually it's
5 fifteen and a half hours I think at one point twelve.
6 HARRISON: Twelve, twelve.
7 STREETER: But anyway, the services that Bryan Hatten was receiving, I'd like
8 those to continue until I make a decision. I'm not going to leave a
9 decision out forever but I, I, I do have to limit that and so what I'm
10 saying to you is whether it's in the plan or not; whether it's on a
11 document or not right then, since I haven't made a decision, I want
12 those to continue, okay? So service coordinator I want you to
13 understand that only because that's just a matter of maintaining the
14 status quo. It doesn't have anything to do with the decision on my
15 part. I'm not making a decision right now, okay?
16 WALKER: Okay.
17 HILL: Can I make a point? These plans are, are, required by Federal law.
18 STREETER: I know that. That's why I'm saying we still have to do a plan.
19 HILL: They have a significant impact on the operations of, in particular
20 this case, in Peter's future. I recommend and urge the Hearing
21 Officer to allow a statement to be attached to the plan indicating
22 that it was the Hearing Officer's order for lack of a better word,
23 that the status quo with regard to this issue, the twelve hours, be
24 continued.
25 STREETER: I think that's an excellent idea. And, you now, Mr. Lawrence, if
26 you will...
27 LAWRENCE: I'll try to draft something.
28 STREETER: ...draft a little paragraph to that affect and...
29 LAWRENCE: Run it by everybody.

1 STREETER: ...and run it by everybody but all I need for it to say is that I'm
2 ordering the status quo to continue as far as the one on one services
3 are presented in the 2003 document. Is the 2003 document still...
4 HARRISON: 2004
5 MRS. BROWN: No, ...
6 STREETER: 2003 document still contained them. 2004 didn't contain them.
7 Two, 2002?
8 LAWRENCE: 2002.
9 HILL: The one in 2004...
10 LAWRENCE: 2003 didn't have it.
11 STREETER: Okay.
12 HARRISON: (Unclear) provided the service.
13 STREETER: They are to continue as they were listed in the 2002 agreement
14 then.
15 MRS. BROWN: Sir, it was in the 2003.
16 STREETER: I thought it was but everybody's disagreeing with me.
17 HARRISON: But at any rate, the twelve hours continues.
18 STREETER: The twelve hours continues. As it, the same as it does in whatever
19 the last document was that contained it.
20 LAWRENCE: All right, got it.
21 STREETER: 2003 or 2002, figure it out. But I want it to continue the way it is
22 until I make a decision. Because I'm going to throw some monkey
23 wrenches later on. Thank you. All right, Mr. Hill. I am very
24 sorry. Please go ahead with your closing remarks as you like.
25 HILL: All right, thank you, sir. Three major areas here. First with regard
26 to the definitions. When we talk about service we have to make
27 sure that we understand what we mean by service. We use it
28 very—very loosely to pertain to any activity involving Peter
29 Brown but from a Medicaid point of view and I suggest from a
30 jurisdictional point of view the Medicaid definition of service must
31 be applied. Peter is getting only one relevant Medicaid service at

1 this time and has been for the last several years if not prior to this
2 and that is residential habilitation. With regard to that service, that
3 service is very all encompassing. It, it really covers community
4 participation. It really covers home care skill development. It's a
5 very all encompassing service. Further, Medicaid requirements do
6 not allow for duplication. They're very serious on that. You
7 know, we have to pay back money and everything if they come
8 and find that we're duplicating services. Part of that then has
9 evolved, if you will, to use a bad term but has come up in this issue
10 of adult companion services. We made a change in 2003 that took
11 away companion services from SLP II. Now Appellant can argue
12 all they want to but there's another forum if there's an argument
13 there. This forum has to take that as a given. Adult companion
14 services is not available to Mr. Brown, Peter Brown, because he is
15 in an SLP II. That's approved by the Health and Human Services.
16 Now, whether or not the so-called informal services that's called
17 enhanced hours is akin to adult companion is irrelevant. If he were
18 in a CTH II then he could get adult companion services. But the
19 definition should be distinctly made reference to whether it's the
20 Federal definition under the CFR which we've already talked
21 about or this informal activity that has been called service. We
22 don't want to bootstrap that informal activity up to a Medicaid
23 level service that is paid for by Federal dollars. Now, moving from
24 that to the history of this case, as I mentioned in my brief, this
25 history is shrouded in past events which some of us are not here.
26 For example, Dr. Coil is not here. We have only Mrs. Brown.
27 Mrs. Brown perhaps has been here through that whole period of
28 time. The other players have moved in and out this sequence of
29 events. But it's clear to say that this twelve hours hasn't been an
30 involving activity. It hasn't been assessed as a need. It has been
31 evolving and it has come through the good graces and advocacy of

1 stand corrected if I'm wrong, but I did not see in there any
2 identification that there was a need in 2003 for enhanced services.
3 What they did say, they re—recapped that he was just receiving
4 this. He's still receiving this. He's still eating his meals, he's still
5 breathing air, he's still walking and talking. It's a matter of course
6 of events. It didn't say that he actually needs this. What it did say
7 that he did needed community participation, home care skills,
8 which is provided under residential habilitation and that service
9 has not changed and is not proposed to be changed and cannot be
10 changed unless it goes through the proper process of team review
11 and recommendation. Now the Circle of Support, contrary to the
12 Appellant's assertion, is not the dictate or the mandate of services.
13 They have input in the sense that they advise the consumer. The
14 service coordinator which is the plan manager, in coordination
15 with Mrs. Brown, as guardian for Peter, they determine what the
16 plan is going to be but, and this is a big but that apparently has
17 been missed all along, that has to be approved by DDSN. I mean
18 what if they came in and said, now Peter is going to have a trip to
19 Paris every year? Can that be dictated? There is a rationale here
20 that there's a balance. I mean we serve a lot of other people and
21 funds do not grow on trees. So there is a—there is a serious issue
22 here of some rationale that has to be applied. That rationale
23 hopefully is done with the service coordinator but there is at least
24 the safeguard of DDSN approval. Now, Peter is a young man that
25 apparently has done well and I think that's due in large part to Mrs.
26 Brown's advocacy, of Peter's own innate desires, his brother's care
27 and love for him and of course his Circle of Friends and no doubt
28 to this enhanced person. But I submit Peter has plateaued. These
29 services have been going on for fourteen years. And you see in
30 there, well, he still needs them. Will he still need them? Of
31 course, he still needs them. He's a disabled individual. He's gonna

1 need this type of activity but not a particular service that's going to
2 give him a clear goal where he's going to be something that he's
3 not or cannot be as a person with moderate, if you will,
4 capabilities. There's a plateau here. Mrs. Walker said that she
5 reviews the background document as a given and the background
6 document said that he dropped down in his ability to independently
7 plan for his activities. What did she do? Nothing, she took it.
8 When presented that by the hearing officer and myself, she said
9 well, I just took it. There's nothing in the plan that addressed that
10 deficiency but it was identified in the 2004 plan as a deficiency and
11 she did nothing to address that. Interesting enough, Bryan Hatten,
12 as I recall his testimony made no reports. He said well, the only
13 report I made was what Peter told me. He either liked it or he
14 didn't like it. So, here we got an enhanced service that doesn't
15 have a feedback component. No valid feedback component. That
16 lacking that feedback component and assessment of whether or not
17 it's a bona fide activity to be paid for is lacking. You can't just
18 pay for something and don't get feedback as to whether or not it's
19 doing any good and based on what we hear (unclear), that Peter
20 sort of plateaued out. Yeah, he needs continued service. Well,
21 everybody needs continued services. It's not unique to Peter, not
22 unique to Peter. So there's been no assessment that he has this
23 unique need. It can be provided, even Mrs. Walker said because
24 Bryan Hatten is Hab. Specialist Associate, just like all the other
25 Hab. Specialist Associates. The way Charles Lea Center
26 approached this thing was to hire Mr. Hatten as a permanent part
27 time employee. I'm sure that there are other positions, other
28 people that Mr. Hatten can service and not be uniquely identified
29 with Peter. Mr. Hatten himself said he had no unique
30 qualifications so he's just another guy that cares for Peter and
31 they've bonded. Well obviously they've bonded. They've been

1 together for twelve years. But there's no mandate that they stay
2 together. What if Charles Lea Center decided to move Mr. Hatten
3 somewhere else, is that a Medicaid appeal? I don't think so. So
4 getting around to the bottom part, there's been absolutely no
5 change in the service. There's no proposed changed in the service
6 and by that mean—I mean in jurisdictional Medicaid service. Yes,
7 the ebb and flow, the day to day changes that occur in the normal
8 residential habilitation provision of services will change as changes
9 are required because a person develops and lives and progresses
10 and regresses, progresses and regresses. This is life. So, with that,
11 let me ask if my counterparts here have anything else to add.
12 LAWRENCE: I have nothing.
13 ROBERTS: Let me just say, two minutes. Just—it struck me and I know it's
14 late in the day so I will not take up too much time at all...
15 STREETER: Go ahead.
16 ROBERTS: ...just two minutes. It seems to me that from what I've heard from
17 both sides is we've got a fairly high functioning individual as far as
18 Peter's concerned. He can read, he can go to events, he can
19 converse with people and they don't even know necessarily that
20 he's mentally retarded when they first start talking to him. He
21 can—he's held a job for an extended period of time. He, he's—he
22 seems to be, even on the video, it appeared to me as though he is a
23 fairly high functioning individual. It strikes me that of all the
24 people that would need a one on one, somebody to be with them
25 every weekend, he's not—(noise, someone says excuse me)—it's
26 okay.
27 STREETER: It's okay, we can use the cleaning.
28 ROBERTS: That's right. He just strikes me—and nobody else that we've
29 heard from staff is receiving such service. It strikes me odd that
30 he's...
31 HARRISON: Objection, we don't have in evidence no one's...

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Barbara Hickey,

Appellant,

vs.

South Carolina Department of Health and
Human Services,

Respondent.

Docket No. 10-ALJ-08-0656-AP

FINAL ORDER AND DECISION

STATEMENT OF THE CASE

This matter is before me pursuant to the appeal of Barbara Hickey (Appellant), from a final decision of the Respondent, South Carolina Department of Health and Human Services (DHHS or Department). This appeal is made in response to Respondent's January 1, 2010 cut in Personal Care Aide (PCA II) services to all those persons who, like the Appellant, rely on these services to live in the community and avoid institutionalization, and to Respondent's denial of Appellant's right to contest this withdrawal of necessary services at a hearing.

On December 1, 2009, Appellant received a letter from Respondent, stating that her in-home PCA II hours had been cut from 50 per week to 28 per week. Petitioner appealed that decision on January 15, 2010. Department of Disability and Special Needs (DDSN) responded to her appeal stating that the "limits cannot be exceeded and must be applied to all [Mental Retardation/Related Disabilities (MR/RD)] Waiver participants." Appellant appealed that decision on January 25, 2010. The hearing officer issued an "interlocutory order" dated January 29, 2010 which stated that she believed that the DHHS had the authority to administer the Medicaid Program in South Carolina, and that the Center for Medicare and Medicaid Services (CMS) had approved the revised Waiver, including the service caps. Petitioner responded on February 12, 2010 stating that she did not understand the decision and requesting a hearing. On

FILED

July 19, 2011

SC ADMIN. LAW COURT

February 17, 2010 the hearing officer dismissed appellant's case stating that she failed to respond to his Interlocutory Order with an allegation of error in fact or in law as ordered. On March 1, 2010, counsel for Appellant filed a Motion to Alter or Amend Judgment and a supporting Affidavit in response to the decision to dismiss Appellant's case and requested a fair hearing be held. On March 10, 2010, DHHS filed a Reply to Appellant's Motion requesting the hearing officer uphold its dismissal of Appellant's case and deny her a hearing. The hearing officer issued a final decision on July 20, 2010 dismissing Appellant's case without a hearing. Appellant received the final decision on July 28, 2010 and appealed to this Court on August 27, 2010. Both parties were represented by counsel at Oral Arguments on April 12, 2011 at the offices of the ALC in Columbia, South Carolina.

Issues on Appeal

1. Has the Department treated its PCA II benefit cap as a binding norm such that promulgation as a regulation is necessary for it to be enforceable?
2. Does inclusion in the waiver document make the PCA II cap enforceable without promulgation?
3. Does S.C. Code § 44-6-90 exempt the Department from promulgating regulations to carry out its duties?
4. Did the Department err in refusing to provide Hickey with a hearing?
5. Did the Department's decision contain erroneous findings of fact?

Standard of Review—

This matter is before the ALC in its appellate jurisdiction pursuant to S.C. Code Ann. § 1-23-600(D) (Supp. 2010). Accordingly, the Administrative Procedures Act's standard of review governs this appeal. See S.C. Code Ann. §§ 1-23-600(E), 1-23-380 (Supp. 2010); see also Byerly Hosp. v. S.C. State Health & Human Servs. Fin. Comm'n, 319 S.C. 225, 229, 460 S.E.2d 383, 385 (1995). The standard used by appellate bodies, including the ALC, to review agency decisions is provided by S.C. Code Ann. § 1-23-380(5) (Supp. 2010). This section provides:

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 [of the agency] 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(5) (Supp. 2010).

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). Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence that, considering the record as a whole, would allow reasonable minds to reach the conclusion the agency reached in order to justify its action. Hargrove v. Titan Textile Co., 360 S.C. 276, 289, 599 S.E.2d 604, 611 (Ct. App. 2004). 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. Id.; Waters v. S.C. Land Res. Conservation Comm’n, 321 S.C. 219, 467 S.E.2d 913 (1996); Grant v. S.C. Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995). However, § 1-23-380(5) requires the reviewing tribunal to consider not only the amount of evidence, but also the quality of that evidence; it must be both “reliable” and “probative,” as well as “substantial.” See S.C. Code Ann. § 1-23-380(5) (Supp. 2010).

An abuse of discretion occurs when a decision is based upon an error of law, such as application of the wrong legal principle; or, when based upon factual conclusions, the ruling is without evidentiary support; or when the judge is vested with discretion, but the ruling reveals no discretion was exercised; or when the ruling does not fall within the range of permissible decisions applicable in a particular case. Ex Parte Capital U-Drive-It, Inc., 369 S.C. 1, 5, 630 S.E.2d 464, 467 (2006). A decision is arbitrary or capricious when no rational basis for the conclusion exists, when it is based on one’s will and not upon any course of reasoning and

exercise of judgment. Converse Power Corp. v. S.C. Dep't of Health & Envtl. Control, 350 S.C. 39, 564 S.E.2d 341 (Ct. App. 2002); Deese v. S.C. State Bd. of Dentistry, 286 S.C. 182, 184-85, 332 S.E.2d 539, 541 (Ct. App. 1985). A decision may be arbitrary or capricious when it is made at one's pleasure without adequate determining principles, or is governed by no fixed rules or principles. Deese, 286 S.C. at 184-85, 332 S.E.2d at 341. Non-uniform, inconsistent, or selective application of authority can indicate arbitrariness. See Mungo v. Smith, 289 S.C. 560, 571, 347 S.E.2d 514, 521 (Ct. App. 1986).

Medicaid MR/RD Waiver Program

Medicaid is an optional state program created under Title XIX of the Social Security Act. It enables states to receive federal financial assistance specifically for the medical care of needy individuals. See 42 U.S.C.A. § 1396; Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007). States are not required to participate in Medicaid; however, if they choose to do so, they must comply with all federal Medicaid laws and regulations. Wilder, 496 U.S. 498; Doe, 501 F.3d at 351; see also Antrican v. Odom, 290 F.3d 178 (4th Cir. 2002) ("Although North Carolina may retain a special sovereignty interest in choosing whether to participate in the Medicaid program, once it elects to participate, it is not entitled to assert that interest to insulate itself from the requirements of the federal program."), cert. denied, Odom v. Antrican, 537 U.S. 973 (2002). As a prerequisite to receiving federal assistance, a state must submit a detailed plan, referred to as the "State Plan," to the CMS for approval. 42 U.S.C.A. § 1396a.

In South Carolina, DHHS is the state agency responsible for administering and supervising the state's Medicaid programs. S.C. Code Ann. § 44-6-30(1); Doe, 501 F.3d at 351. DDSN is responsible for the state's treatment and training programs for people with mental retardation and related disabilities. Doe, 501 F.3d at 351. Accordingly, in some instances, such as the case at hand, DDSN can act as an agent for DHHS. Id.

Medicaid normally provides funding for individuals with mental disabilities who live in an institution. However, states may make a request to the CMS for a "waiver" to pay for otherwise non-covered Home and Community Based Services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized as long as the services are cost effective. 42 U.S.C.A. § 1396n(c).

States must seek approval for these waiver programs from the CMS. If a waiver is approved, the CMS waives compliance with state program requirements while permitting states to remain eligible for reimbursement with federal grants. *Id.* The waiver program provides Medicaid reimbursement to participant states for providing HCBS to individuals who would otherwise require institutional care. *See* 42 U.S.C.A. § 1396n(c). Waivers are approved for a period of two to three years and may be renewed thereafter. Under a program operated by DDSN, CMS has waived the requirement that an individual live in an institution to receive services. In this appeal, the waiver program at issue is the MR/RD Waiver Program. The MR/RD Waiver Program permits a recipient to receive services at home or in the community, rather than in an Intermediate Care Facility Mental Retardation (ICF/MR) such as a nursing home. *Doe*, 501 F.3d at 351.

On January 1, 2010 a new MR/RD waiver renewal became effective following approval by CMS. The renewed waiver document includes a cap of 28 hours per week for PCA II services. PCA II services consist of hands-on personal care to help a participant accomplish the activities of daily living such as bathing, toileting, dressing and eating.

I. Has the Department treated its PCA II benefit cap as a binding norm such that promulgation as a regulation is necessary for it to be enforceable?

The central issue raised by the Appellant in this case is whether the Department is entitled to rely on an amendment to the MR/RD waiver document to cut Appellant's PCA II services from 50 to 28 hours per week. It is uncontroverted that the cap on PCA II services was not promulgated as a regulation under the Administrative Procedures Act, S.C. Code Title 1, Chapter 23 (APA). The Department makes three arguments in support of its position that it properly applied the cap on PCA II services in this case without promulgating the cap provision as a regulation.

The Department first asserts that the cap on CPA II services is not a rule that must be promulgated as a regulation in order to be enforceable. "[W]hether an agency's action or statement amounts to a rule—which must be formally enacted as a regulation -- or a general policy statement -- which does not have to be enacted as a regulation -- depends on whether the action or statement establishes a 'binding norm.'" *Sloan v. S.C. Bd. of Physical Therapy Exam'rs*, 370 S.C. 452, 636 S.E.2d 598 (2006). In order for an agency to create a "binding" rule

it must be promulgated as a regulation. Home Health Serv., Inc. v. S.C. Tax Comm'n, 312 S.C. 328, 440 S.E.2d 375 (1994). The key factor in determining whether a policy statement establishes a "binding norm" is the extent to which the challenged policy leaves the agency free to exercise its discretion to follow or not follow the policy at issue in a particular situation. Home Health Serv. Inc. v. S.C. Tax Comm'n, 312 S.C. 324, 328, 440 S.E.2d 375, 378 (1994). If the policy at issue "so fills out the statutory scheme" that the agency will only look to whether the policy's criteria are met in taking action or rendering a decision, the policy will be considered a "rule" or "regulation." Id. As long as the agency remains free to consider the individual facts in taking action or rendering a decision, the policy at issue will not be considered a "binding norm." Id. Thus, to determine whether a policy or guideline establishes a "binding norm," courts look to the actions of the agency, not to the labels given by the agency.

In this case, the Department argues that it has not treated the cap on PCA II services as a binding norm. I find no support for this argument in the record; the Department has consistently treated the PCA II services cap as a binding norm. In its initial letter denying Hickey's request for continued PCA II services benefits at the level she formerly received, the Department stated,

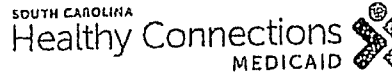
[L]imits or caps were placed on services in the MR/RD Waiver. Approval for these limits or caps was obtained from the [CMS]. These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants. While we understand and appreciate the hardship these changes may place on you, we are not at liberty to exceed the established limits.

In response to Hickey's appeal of that decision, the hearing officer upheld the Department's decision denying Hickey a hearing in part because, the Department

need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients. The reduction in Petitioner's PC II hours was imposed by caps and limits on these, and other services specified in the MR/RD Waiver as renewed effective January 1, 2010, and imposed upon all Waiver participants. These changes in the Waiver were approved in advance by ...CMS....For the purposes of this decision, it is presumed that this approval, inclusive specifically of the changes approved, by CMS carries the force and effect of law.

Thus, because the Department's decisions in this case look only to whether the services Hickey received were within the cap and not to any other standard or factual issues, the cap on PCA II services was treated as a binding norm and not as a general policy statement. The Department did not treat the cap as a policy statement that it was free to exercise its discretion to

rec'd Nov 20, 2013
Pkt



Nikki Haley GOVERNOR
Anthony Keck DIRECTOR
P.O. Box B206 • Columbia, SC 29202
www.scdhhs.gov

November 19, 2013

CERTIFIED MAIL

Patricia Harrison, Esquire
611 Holly Street
Columbia SC 29205

RE: Administrative Decision in the Appeal Matter of Brook Waddle v. SCDHHS
Appeals' Case # 07-MISC-028
Medicaid # 6780499394

Dear Ms. Harrison:

Enclosed please find the Administrative Decision in the above-referenced matter.

Any party has the right to petition for further review of this Decision, 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 30 days of the receipt of this Decision. A copy of the Notice of Appeal should be provided to counsel for the opposing party. The Notice of Appeal must be submitted in accordance the Rules of Procedure for the S.C. Administrative Law Court. This matter was previously transcribed to assist me in producing this Decision. I believe the attorneys for both parties have a copy of this transcript. Should either party pursue an appeal, I will certify the transcript and produce it to the Administrative Law Court.

Sincerely,

Elizabeth B. Hutto
Program Director, Division of Appeals and Third Party Liability
Interim CFO, SCDHHS

EBH/ss
Enclosures (2)

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NOV 20 2013

SC Department of Health and Human Services

Patricia Harrison Esquire
November 19, 2013
Page Two

cc: George Malcy, Department Head, Community Waivers, SCDHHS
Office of General Counsel, SCDHHS
Richard Hepfer, Esquire, Deputy General Counsel, SCDHHS
Tana Vanderbilt, Office of General Counsel, SCDDSN
Linda Veldheer, Director, HASCI Waiver, SCDDSN
Brook Waddle
Sandra Waddle

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.

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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.

STATE OF SOUTH CAROLINA	)	BEFORE THE DIVISION OF
	)	APPEALS AND HEARINGS
COUNTY OF RICHLAND	)	SOUTH CAROLINA DEPARTMENT OF
	)	HEALTH AND HUMAN SERVICES
B.W.,	)	
	)	
Petitioner,	)	FINAL ADMINISTRATIVE
	)	ORDER
-v-	)	
	)	
South Carolina Department of Health	)	
and Human Services,	)	Appeals' Case #: 07-MISC-028
	)	(Remanded)
Respondent.	)	
_____	)	

JURISDICTION

Procedure in this case is governed by the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services to administer various programs and grants (See e.g., S.C. Code Ann. § 44-6-10, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (27 S.C. Code Regs. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. § 1-23-310, et seq.).

BACKGROUND

The Petitioner in this matter was injured in an automobile accident in 2005, which rendered her quadriplegic. At the time of the accident, the Petitioner was 17 years old. She has difficulty speaking due to subsequent injuries to her larynx sustained during her initial hospitalization. She breathes through a tracheostomy. The Petitioner became eligible for Medicaid-covered services shortly after the accident. Since her May, 2007 return home, she has been receiving services under the South Carolina Head and Spinal Cord Injury (HASCI) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through the South Carolina

Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which, by getting the federal agency to "waive" certain generic requirements of the Medicaid program, States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. This and other Waivers operated by SCDDSN are for home and community based services under Section 1915(c) of the Social Security Act [42 USC §1396n(c)]. These types of Waivers allow services to be provided in the home or community, in lieu of institutional services. The South Carolina Department of Health and Human Services (SCDHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and is responsible for the overall administration of the Waiver.

In February 2007, in anticipation of the Petitioner's discharge home from her initial hospital stay, the Petitioner's Service Coordinator (Ms. Gosnell, at that time) completed her Service Plan. The parties disputed several aspects of that plan including the nursing and service hours to be provided to Petitioner upon her discharge home. That dispute forms the basis of the present appeal. There are three types of services at issue in this case:

1. RN services, where a registered nurse can provide nursing care, complete certain medical tasks, and assess the Waiver Participant;
2. LPN services, where a licensed practical nurse can provide nursing care and complete certain medical tasks;
3. Attendant care services, where a qualified provider can help with activities of daily living such as light housekeeping, feeding, clothing, or bathing. Only an RN, LPN, or trained family member can provide skilled care.

In 2007, this matter was originally before the Appeals Division of the SCDHHS, but was dismissed, essentially for confusion about joinder of the issues. Thereupon, the matter was

appealed to the Administrative Law Court (ALC) which remanded the matter for an evidentiary hearing at SCDHHS. After the hearing (April 14, 2009), the SCDHHS Hearing Officer's Decision, issued on July 9, 2009, was appealed and, on July 30, 2012, the ALC once again remanded the case to the SCDHHS Appeals Division for a determination of the five issues listed below.

A hearing was held over two days: October 25, 2012 and October 31, 2012 at the SCDHHS Offices. Richard Hepfer, Esquire, represented Respondent and called as witnesses: Dr. Linda Veldheer, SCDDSN, Director, HASCI Division; Anita Atwood, SCDHHS, HASCI Waiver Administrator; Zanipha Mohammed, SCDHHS, Durable Medical Equipment; and Ashley Wingo, the Petitioner's current Service Coordinator. Patricia Harrison, Esquire, represented the Petitioner and called as witnesses: Sandra Ray, Speech Pathologist and Rhonda Galus, the Petitioner's LPN. In addition to the testimony of the witnesses, I have Declaration Statements from the Petitioner, her mother, S.W., her father, J.W., and Kathy Hoover, RN. Additionally, I have affidavits of Don Kovach of Dynavox Mayer-Johnson and Lennie Mullis.

The following documents were admitted as exhibits for the Petitioner:

1. A 9/24/2012 letter from Linda Veldheer to Petitioner indicating that, if the Petitioner approved, her services would be restored to the May 2007 levels;
2. Charles Lea Center's Estimated Annual cost of services for Petitioner for 2010, 2011, and 2012;
3. A 3/14/2007 Notice of Denial of an apparent request for additional nursing services;
4. A 3/30/2007 Notice of Denial of an apparent request for additional nursing services;
5. A 3/29/2007 Physician's Order for Petitioner for 28 hours per week of RN and 84 hours per week of LPN services, and a companion letter from Dr. Silvestri;

6. Various DDSN Manual provisions;
7. A March 18, 2010, Discharge Summary from Greenville Hospital System;
8. The Service Coordinators' Record of Contact for the Petitioner dated for various times between 12/1/09 – 09/27/12;
9. DDSN HASCI Form 15 (9-10) dated 2/22/12 by Dr. Katherine Lumpkin;
10. ICD-9 Description of the E2510 Speech Generating Device;
11. Telephone Declaration of J. W. taken by Petitioner's attorney;
12. Telephone Declaration of B. W. taken by Petitioner's attorney;
13. Telephone Declaration of S. W. taken by Petitioner's attorney;
14. Affidavit of Don Kovach;
15. Declaration of Kathy Hoover, RN;
16. Attachments to Declaration of Kathy Hoover, RN;
17. Section 2 of the Home Health Services Manual, updated 10/01/12;
18. Section 2 of the Private Rehabilitation Therapy and Audiology Services Manual, update 10/01/12;
19. An August 20, 2010, News Release from the Comptroller General's Office about the budget challenges of FY 2010;
20. A May 8, 2009, cover letter enclosing documentation about the request for the speech generating device;
21. Affidavit of Lennie Mullis;
22. Packet of documents regarding the requested speech generating device;
23. Detailed Claims Report of Petitioner dated 10/16/2012;
24. Personal Care Needs Form, no date, for B.W.;

25. DDSN Annual Accountability Report, FY 2011-2012;
26. Document entitled Head and Spinal Cord Injury (HASCI) Waiver Recommendations for Revised Service Limits, Attachment D;
27. DDSN Service Coordination Manual, Revised July 1, 2011;
28. Documents from a Nursing Services Review of Petitioner by Vivian Koon; and
29. Photographs of Petitioner.

The following documents were admitted as exhibits for the Respondent:

1. Documents related to the original request for a speech generating device; and
2. The Current HASCI Waiver document.

In addition to the exhibits listed above, the 120 page record of the 2007 attempted appeal along with the 1,582 page record of the 2009 fair hearing were also a part of the record in the current matter. Note that the undersigned Hearing Officer was new to this case in 2012 as the Hearing Officer who presided over the 2007 and 2009 matters is deceased.

ISSUES

The Administrative Law Court has remanded this appeal to determine the following issues:

1. The weekly hours of registered nursing that are needed by the Petitioner, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.
2. The specific type of care and number of weekly hours of each type of care required by the Petitioner during the course of her treatment since her discharge from the hospital in May of 2007 consistent with the Medicaid Program, and the principle that the mother is not legally responsible for caring for the Petitioner.

3. The number of hours of the authorized care described in #2, above, that has been provided by the mother (according to her qualifications), and the cost of that care, which amount shall be paid to the mother.
4. In the future, the mother should be allowed to provide whatever care she is qualified to provide within the authorized hours of service set as described in #2, above, and shall be paid for such services at a rate to be determined upon remand.
5. The cost of an average digital speech device of the type described by Dr. Burton shall be determined and paid to the Petitioner to defray the cost of the more expensive device she purchased.

HISTORY OF SERVICE HOURS DISPUTE

The Service Plan drafted by the Petitioner's Service Coordinator in February 2007 required 28 hours per week of Personal Care Aide (PCA) services; 56 hours per week of nursing care provided by a Licensed Practical Nurse (LPN); 14 hours per week of nursing care provided by a Registered Nurse (RN). The RN services were to be evaluated after 30 days but continue in some amount per week. The care to be provided under this Service Plan totaled 98 hours per week. However, the Petitioner's treating physicians ordered 28 hours per week of RN services; 84 hours per week of LPN services for a total of 112 hours of skilled care per week. The treating physician also ordered attendant care whenever a nurse was not present. Presumably the attendant hours would be covered by the Petitioner's parents as the Petitioner's mother was the only attendant available that could provide skilled care. The Petitioner remained hospitalized as the parties continued to negotiate the Petitioner's care upon discharge. B.W. v. SCDHHS, Docket No. 09-ALJ-08-03440AP (S.C.A.L.C. July 30, 2012).

On March 14, 2007, DDSN issued a HASCI Notice of Denial form notifying the Petitioner that Medicaid Waiver Nursing Services were denied for exceeding service limits. "B___ will already be receiving the maximum number of RN hours per week (44) and can not receive additional hours of LPN services according to the HASCI waiver guidelines. The HASCI waiver manual specifically states: The maximum number of nursing services/units that can be funded by the HASCI waiver is 60 hours per week provided by an LPN-OR-44 hours per week provided by an RN." Petitioner's Exhibit 3. This notice did not include any reference to a supporting statute or regulation as a basis for this decision nor did the notice provide any information regarding the continuation of benefits pending an appeal. The Petitioner was under 21 at the time this notice was issued. This notice was sent to the Petitioner's home even though she was hospitalized at this time. Although the notice cites a maximum number of nursing hours, according to the Director of the HASCI Waiver, Dr. Linda Veldheer, there were no limits under the Waiver at this time. Instead, this notice was following "HASCI Waiver procedures." T. at 60. At this time HASCI did not have caps that were part of the Waiver document but SCDDSN was following "limits we were applying at the direction of HHS." Id.

On March 29, 2007, the Petitioner's treating physician, Dr. Silvestri, ordered 84 hours per week of LPN care; 24 hours per week of RN care and attendant care at all times when the nurse was not present. On March 30, 2007, DDSN sent a denial notice stating that due to the Medicaid Waiver, the ordered Nursing Services exceeds service limits: "HASCI Waiver services (home and community based services) can not be offered when it can reasonably be expected that the cost of services to B___ would exceed the cost of a nursing facility level of care." Petitioner's Exhibit 4. Again, no statute or regulations were cited on this notice nor was there any justification or analysis regarding whether the cost for this care would be greater than the cost of

a nursing home. Ms. Atwood testified that the Waiver limits looked at the aggregate cost of institutional vs. non-institutional care and that there were no caps applied to individuals. T. at 10-14. Dr. Veldheer testified that it would be improper for a denial to be based on the individual's service costing more than nursing home care since there are no individual limits. T. at 57. The Petitioner was under 21 at this time. This notice made no mention of continued benefits pending appeal. Like the previous notice, this notice was also sent to the Petitioner's home although she was still hospitalized at MUSC.

The notices sent to B.W. refer to limits within the HASCI Waiver. However, the Respondent presented conflicting testimony regarding whether there was in fact a limit within the HASCI Waiver at this time. According to Ms. Atwood, the HASCI Waiver Administrator for SCDHHS, there were no limits on nursing and attendant care services within the HASCI Waiver prior to July 2008. T. at 6. Dr. Veldheer asserted that SCDDSN applied limits to HASCI Waiver participants in 2007. T. at 61. Dr. Veldheer explained that, although there were no limits in the Waiver document at this time, "we were applying those kinds of limits informally." T. at 42. Dr. Veldheer claimed that in spite of the language contained in the March 30, 2007 notice, SCDDSN was not applying an individual limit. She seemed to indicate the notice is a local issue: "The service coordinator wrote this comment. I don't agree with this comment but this is what a service coordinator at the local level wrote." T. at 61. In rebuttal testimony, Dr. Veldheer contradicted her earlier statement and testified that the HASCI Waiver did not have an individual limit at the time the 2007 notices were issued. T. at 243.

On April 28, 2007, while still hospitalized, the Petitioner requested the present appeal due to the denial of the nursing and attendant care services ordered by her treating physicians. The

Petitioner was discharged on May 8, 2007, and was to receive the services that had been included in the service plan created by the Service Coordinator in February 2007.

On May 9, 2007, the day following the Petitioner's discharge from the hospital, she sent a letter to SCDDSN and SCDHHS stating she "...reserves all rights. Her acceptance of services in order to secure her release from her current, considerably more expensive institutional placement cannot be construed as a waiver, consent, limitation, estoppel, or other indication of agreement with the restrictions imposed by SCDDSN and SCDHHS." Record of 2007 Matter at 58.

In July 2008, while this appeal was pending, the Respondent reduced the Petitioner's service hours to 32 hours per week of LPN and 48 hours per week of attendant care plus seven hours per month of respite care. T. at 44. There is no notice in the record regarding this service reduction. This reduction occurred while the current appeal was pending and while the Petitioner was under 21. Dr. Veldheer testified that in July 2008, services were limited to 60 hours of LPN per week or 45 hours of RN per week or a combination not to exceed \$1,425 based on an LPN rate of \$23.75 per hour, RN rate of \$31.35 per hour. T. at 43. However, when asked about this weekly limit on cross examination, Dr. Veldheer asserts, "I never said that...We've never had weekly limits." T. at 66. According to Ms. Atwood, there were no limits on nursing services or attendant care prior to July 2008. T. at 6. The Petitioner was still not receiving RN services due to the Service Coordinator's inability to locate an RN and the mistaken idea that the RN could only provide 2 hours of care per day.

In July 2009, while this appeal was pending, the Petitioner's nursing hours were again reduced. Her LPN hours were brought down to 22 hours per week while the attendant care was increased to 48 hours per week along with 12 hours per week of respite care. T. at 45. There is

no notice in the record regarding this reduction. As with the 2008 service reductions, the 2009 reductions occurred while the current appeal was pending.

In 2010, the HASCI Waiver was renewed and an across the board cut was instituted. There was no individual assessment to determine whether the cuts were appropriate, no cost analysis to determine if less expensive services could be used, nor any medical review of the consequences of the cuts. T. at 20-21 and 25. At this time, Petitioner's services remained the same (22 hours per week LPN and 48 hours per week attendant) as the 2009 reduction had already put her services within the across the board cuts. T. at 45. According to the Respondent, since 2010, the combination of nursing and attendant care cannot exceed 70 hours per week (10 hours per day). Prior to 2010, there was a 12 hour per day limit (total limit of 84 hours per week).

In 2011, Petitioner's services went to 34 hours per week of LPN, 36 hours per week of attendant care, and 12 hours per week of respite care. This is the Petitioner's current authorization and is the Waiver limit for the combination of attendant care and nursing, according to Dr. Veldheer. T. at 45.

Prior to the hearing, the Respondent sent the Petitioner a letter offering to restore her HASCI Waiver services to the levels of May 2007 which the letter characterized as: 2-3 hours per week of RN services, 8 hours per day of LPN services, 4 hours per day of attendant care, physical therapy (P.T.), occupational therapy (O.T.), speech therapy (S.T.), and Psychological services. Petitioner's Exhibit 1. This offer totaled 83-84 hours per week of skilled and attendant care which exceeds the current waiver limits. The timing of the letter indicates that it was sent in an attempt to settle this dispute.

At some point while this appeal was pending, the Petitioner's parents divorced and the Petitioner's mother, S.W., became the Petitioner's sole caregiver.

Issues 1 and 2 will be considered together as the facts and law are inter-related.

Issue 1 - The weekly hours of registered nursing that are needed by the Petitioner, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.

Issue 2 - How many weekly hours of each type of care and services have been needed by Appellant during the course of her treatment since her discharge from the hospital in May 2007 consistent with the Medicaid Program, and the principal that the mother is not legally responsible for caring for the Appellant.

DISCUSSION

At the time of the Petitioner's return home in 2007, her Service Plan called for two hours per day, seven days per week of RN care; however, the Service Coordinator was unable to find an RN in the area willing to work a two hour shift and those care hours went unfilled. As the limited daily hours appeared to be a roadblock to getting the Petitioner the RN services to which she was entitled, the Petitioner's parents asked the Service Coordinator whether they could combine the 14 hours per week so that an RN could provide services for longer periods of time over fewer days. The Service Coordinator informed the family that it was not possible to combine these nursing hours under the Waiver and that they must use two hours per day. Petitioner's Exhibit 13, Declaration of S.W. at 6. However, two witnesses for the Respondent, Ms. Atwood and Dr. Veldheer, acknowledged that Waiver participants can combine nursing hours. T. at 20 and 82. Both parties agreed that it is not possible to find an RN who would work a two hour shift. T. 199-200 and 221. Dr. Veldheer testified that because it is difficult to get an

with nursing needs will receive. T. at 226-227. The centralized nurse can determine whether a service is medically necessary. T. at 22.

Dr. Veldheer stated that if a treating physician ordered nursing hours that exceeded waiver limits, the SCDDSN centralized nurse would not give any deference to that medical order. Dr. Veldheer explained that the form used by SCDDSN does not allow the doctor to designate a recommended number of nursing hours. The doctor identifies the condition and the specific skilled nursing care they require. If the doctor ordered hours that exceeded limits, the centralized nurse would "not consider it." T. at 232.

The Respondent has not presented any medical witnesses with direct knowledge of the Petitioner's condition at either of the two hearings in this matter. The Respondent's Medical Director, Dr. Marion Burton, testified during the 2009 hearing. Dr. Burton had not met the Petitioner prior to the 2009 hearing. He was "somewhat familiar" with the case. Record of 2009 Matter at 47-48. Although Dr. Burton could not recall the specific details of the care the Petitioner was to receive upon discharge from the hospital, he believed she was to receive about 50 hours of skilled care per week and that, along with the supporting care of the parents and attendant care, was adequate to maintain the Petitioner at home. *Id.* He has no training in the treatment of head or spinal cord injuries and admitted that he was only vaguely familiar with the HASCI Waiver program. Record of 2009 Matter at 92-93. Dr. Burton admitted that he did not have the expertise to override the orders of a treating physician. His decision to deny services was based upon Department guidance and the SCDHHS provider manual policy. Record of 2009 Matter at 97, 109-111.

Tracheostomy in place – tracheoesophageal fistula

Dysphagia – GERD

Hypothyroidism

Staph coag negative bacteremia – treated with Rocephin”

Petitioner’s Exhibit 28 at 2.

The nurse’s 2011 medical record review does not indicate any improvement in the Petitioner’s condition. The nurse supported the Petitioner continuing with the ordered 22 nursing hours per week. *Id.*

According to the nurse’s 2012 report, the Petitioner’s medical diagnoses remain the same since the last review of August 9, 2011. Nurse Koon notes that the Petitioner continues to require assistance with her bowel program and supra pubic catheter care. She continues to experience urinary tract and kidney infections that require hospitalizations and experienced bilateral nephrolithiasis during a recent hospitalization. The Petitioner requires suctioning “several times day” and trach care “frequently.” The SCDDSN nurse also reported that the Petitioner requires “continued monitoring” of her skin integrity and turning to prevent decubitus ulcers. She recognized the need for medical monitoring as well as for care for anxiety, depression and seizures. Nurse Koon summarized that the Petitioner continues to require skilled care for her “multiple medical problems.” She also supported the continuation of the current authorized nursing care at 34 hours per week. Petitioner’s Exhibit 28 at 3.

Like the 2011 medical record review, the 2012 does not note any improvement in the Petitioner’s condition. In fact, the nurse has supported an increase in nursing hours by 12 hours per week. This increase in nursing hours seems to indicate that either the Petitioner’s condition

has worsened over the past year or that the previous year's 22 nursing hours per week were inadequate.

Ms. Galus testified that, on one occasion, the Petitioner's mother became ill and could not care for the Petitioner overnight. Ms. Galus stayed overnight with the Petitioner (without pay, as a favor to the family as these nursing hours offered by Ms. Galus were beyond the care that the Petitioner's Service Plan covered). Ms. Galus recounted that she was unable to sleep during the night as the Petitioner needed care every 2-3 hours including suctioning. Ms. Galus described the situation for the Petitioner and her mother as, "very, very challenging." With the exception of her mother, the Petitioner does not have good family support to help with her care. T. at 175-177. If the Petitioner's LPN is sick, there is very little substitute coverage available. Usually, there will be no substitute coverage or very little coverage on days that the LPN is out. T. at 199. Ms. Galus also testified that the Petitioner is suffering from depression and has become withdrawn. T. at 185.

Ms. Galus testified regarding the challenges surrounding Petitioner's difficulty with speaking and being understood as she cannot immediately alert her caregiver when she needs care. When she does attempt to explain her needs, it is difficult to understand as she speaks in a whisper. This communication barrier can at times delay the Petitioner getting timely care. T. at 196. The Petitioner has a whistle near her pillow which she can reach by turning her head. The whistle is used as a warning device if she is in need of care or suctioning. The Petitioner also drinks water through a straw in a cup which is also positioned within her reach by turning her head. However, if the Petitioner coughs, her arms can fly up and knock the whistle and cup out of her reach. If the Petitioner cannot reach her whistle, she could be in danger. T. at 182.

Ms. Galus testified that if the Petitioner's mother became ill, there would be no one to take care of the Petitioner. However, if the Petitioner had the hours that were ordered by her doctor (28 hours of RN and 84 hours of LPN), that would extend the Petitioner's mother's ability to care for her T. at 197-198.

The Petitioner and her mother testified via Affidavit. Although this testimony was not subject to cross examination by the Respondent; it was consistent with that of Ms. Galus in describing the Petitioner's physical condition. The Petitioner's Affidavit also provided additional details regarding her physical state including the information that she can shrug her shoulders but cannot move her body below her shoulders. The Petitioner also testified that she breathes through a trach which has to be suctioned throughout the day. She cannot breathe when she gets a mucus plug in her trach and there is no forewarning of when this will occur. Petitioner's Exhibit 12 at 3.

The Petitioner testified in the 2009 hearing that she did not want to go to a nursing home and preferred to live at home. Record of 2009 Matter at 149. Her affidavit testimony is consistent with this desire to remain in her home. She would, "rather die than go to a SCDDSN Regional Center like Whitten Center or to attend a workshop..." She also testified that she is frightened by the grand mal seizures that she has suffered. Petitioner's Exhibit 12 at 3.

I therefore find:

1. Community-based treatment is appropriate for the Petitioner and she seeks to continue community-based care.
2. The initial service plan authorized the Petitioner for 14 hours of RN services per week and required that the Petitioner's continuing need for RN services be re-evaluated after

30 days. The Petitioner's treating physician ordered 28 hours per week of RN services and 84 hours per week of LPN services.

3. The Petitioner's Service Plan also authorized 56 hours per week of LPN care and 28 hours of Attendant care.
4. The denial notices that were issued to the Petitioner prior to her initial discharge from the hospital were improper as they did not contain the statutes or regulations the actions were based upon nor did they provide instruction on how to appeal the negative action. The denial notices were sent to the Petitioner's home, although she was hospitalized at the time. Additionally, the reasons for the denials given in these notices were erroneous according to the testimony of the Respondent. The Petitioner was under 21 at the time that the denial notices were issued. The Petitioner turned 21 on January 14, 2009.
5. While pending the resolution of this appeal, the Petitioner's services were improperly reduced several times. The reductions occurred without notice and the opportunity to appeal. The reduction in 2008 occurred before the Petitioner turned 21.
6. In July 2008, the Petitioner's hours were reduced to 32 hours of LPN and 48 hours of attendant care (total of 80 hours per week). There was no notice provided to the Petitioner for this reduction.
7. In 2009, the Respondent again improperly reduced the Petitioner's service hours to 70 hours per week of combined LPN and Attendant Care. This reduction occurred during the pendency of this appeal. The Respondent again failed to provide proper notice.
8. At some point after the Petitioner was discharged from MUSC in 2007, her father moved out of the home and the Petitioner's mother became the sole family member providing

care. The Respondent should have conducted a new assessment of the Petitioner's needs when her family support was reduced to one person.

9. Upon discharge on May 9, 2007, the Petitioner was unable to find a provider of RN services willing to work the authorized hours per week and thus was unable to fill the position. The inability to locate a suitable RN was due to the Service Coordinator's erroneous assertion that the Petitioner could only receive RN hours in daily two hour increments. The Petitioner and her family relied upon this erroneous assertion. The Petitioner still has not received RN hours in her home since her initial discharge from the hospital in 2007.
10. During the pendency of this appeal, the Petitioner's mother has provided all of the care that the Respondent failed to provide due to both miscommunication and service reductions.
11. Witnesses for both parties concur that it is not possible to locate an RN who would be willing to travel to work for such a short period each day. The Petitioner and RN provider should have had the opportunity to schedule the RN hours so that the schedule best met their mutual needs.
12. The Petitioner was not re-evaluated 30 days after her initial discharge from the hospital to determine whether the 14 hours per week of RN should continue.
13. Under the current nursing hours review process, the Respondent does not seek the recommendation of the treating doctor regarding nursing hours needed by HASCI Waiver participants. The current authorization process for nursing hours requires a centralized SCDDSN nurse to perform a record review.

14. The Respondent has not provided any records which indicate that a physician for the Respondent has ever reviewed the Petitioner's medical needs.
15. The medical records review conducted by the Respondent and the testimony of witnesses for both parties indicate that the Petitioner is a quadriplegic, who relies upon a tracheostomy to breathe, and suffers from several complicated medical conditions including recurrent pneumonia, seizures, and skin break down. Due to her condition, she is at continued risk for infection. She requires constant care and cannot be left alone. Based on the testimony of witnesses for both parties, an RN should have been involved in the Petitioner's care on at least a weekly basis due to the complexity of the Petitioner's medical needs.
16. The Respondent relied upon the evaluation of a nurse to determine the hours of skilled care needed by HASCI Waiver participants.
17. An RN can assess the Petitioner's lung functioning, skin condition, and infection risks. According to the testimony of both parties, the Petitioner would benefit from a weekly assessment conducted by an RN.
18. Due to the Petitioner's complicated medical conditions and her dependence upon a single caregiver, she should receive the maximum services available under the HASCI Waiver. For this Petitioner, a four hour block of RN services is the minimum necessary per week. However, under the current rules, the Petitioner may adjust the nursing hours between RN and LPN services. The Petitioner may therefore receive up to a maximum of 45 hours per week of RN care should she so choose, bearing in mind that limit works in tandem with the limits for LPN services and an increase in RN hours may result in a

decrease in LPN hours. Current Waiver limits are 45 hours per week of RN or 60 hours per week of LPN or some combination not to exceed \$1,425 per week.

19. The Petitioner would have benefitted from 14 hours of RN care per week through June 30, 2007, and at least four 4 hours of RN services with increased RN, if the Petitioner had desired, up to the waiver limit. The Petitioner should have received RN services weekly through the present time. The Petitioner has been maintained at home with fewer services than those to which she was entitled due to the extraordinary efforts and dedication of her mother.
20. The Petitioner's benefits should have continued at the levels ordered by her treating physician during the pendency of this appeal.
21. There are RNs available in the Petitioner's service area who will cover four hours or more of care per week.

LEGAL DISCUSSION

Medicaid recipients have due process rights prior to an adverse action impacting their Medicaid benefits. 42 C.F.R. § 431.200 *et seq.*; *Goldberg v. Kelly*, 397 U.S. 254 (1970). An action is defined as, "...a termination, suspension, or reduction of Medicaid eligibility or covered services." 42 C.F.R. § 431.201. Federal regulations require that the notice of adverse action must explain the action to be taken and the reason, cite the specific legal support for the action, explain the beneficiary's hearing rights, the right to representation, and the rights to continued benefits, and must be sent 10 days before an adverse action. 42 CFR §§ 431.206, 431.210, 431.211, 431.230. The regulations also require the agency to make available to the beneficiary the specific policy materials so that the beneficiary can determine whether to request a fair hearing and can prepare for the fair hearing. 42 CFR § 431.18(e).

The HASCI Waiver provides the same requirements regarding the availability of continued benefits that the federal regulations require. The HASCI Waiver Procedural Manual states that "the State may not reduce, deny or terminate services until a decision is rendered after the hearing. (For example, if the individual/legal guardian did not authorize a reduction of his/her Waiver services and the Waiver services are going to be reduced, the individual/legal guardian must be given written notice regarding the reduction which includes a 10 calendar day waiting period before the Waiver services are reduced. The Waiver services that were going to be reduced will continue as authorized prior to the request.)" SCDDSN Manual, Petitioner's Exhibit 6 at 5-7, emphasis in original. According to Dr. Veldheer, if a participant requests continuation of services, those services are continued through the Administrative Law Court level. T. at 51.

Medicaid eligible children, under age 21, are entitled to the screens and services provided by the Early and Periodic Screening Diagnostic and Treatment (EPSDT) provisions of the Medicaid law. 42 U.S.C. § 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). EPSDT requires that Medicaid children receive all of the medical services they need to diagnose, treat, or ameliorate their health needs regardless of whether these services are covered for adults in the state's Medicaid plan. 42 U.S.C. § 1396d(r)(5). The Petitioner turned 21 on January 14, 2009 and was entitled to EPSDT protections up until that time.

EPSDT, waiver services, medical necessity, and the role of the treating physician and the state's physician in determining medical necessity are all addressed in *Moore v. Reese* in which the Georgia agency was attempting to reduce the nursing hours of a disabled child in a waiver program. In that case, the Eleventh Circuit held that: (1) the State is required to provide medically necessary services to correct or ameliorate an illness or condition of a participant

under age 22 pursuant to EPSDT; (2) a state Medicaid plan must include reasonable standards for determining eligibility for and the extent of medical assistance; (3) a state may adopt a definition of medical necessity that places limits on a physician's discretion, but it must establish reasonable standards for physicians to use in determining what services are appropriate; (4) the treating physician assumes the primary responsibility of determining what treatment should be made available to his patients, but both the treating physician and the state have roles to play and a private physician's word on medical necessity is not dispositive; (5) a state may establish the amount, duration, and scope of Medicaid services, but the services must be sufficient in amount, duration, and scope to reasonably achieve the purpose of the program; (6) a state may place appropriate limits on a service based on such criteria as medical necessity by reviewing the medical necessity of treatment prescribed by a doctor on a case-by-case basis, and the State may present its own evidence of medical necessity in disputes between the state and Medicaid patients. *Moore v. Reese*, 637 F. 3d 1220, 1255 (11th Cir. 2011).

Upon remand, the Georgia District Court held that the attempted reduction in nursing hours violated the Medicaid Act. The District Court found the opinion of the treating physician was entitled much greater weight than that of the state's physician who had only reviewed the plaintiff's case on one occasion and relied on case summaries prepared by a nurse rather than reviewing the plaintiff's medical records. *Moore v. Cook*, Civ. Act. No. 1:07-CV-631-TWT, 2012 WL 1380220 (N.D. Ga. Apr. 20, 2012). *Royal v. Cook* also involved a disabled child receiving nursing services through a waiver program. In that case, the District Court found the reduction of nursing hours violated the Medicaid Act again determining that the treating physician's opinion was entitled to greater weight due to the state doctor's lack of any direct knowledge of the child's medical needs. *Royal v. Cook*, Civ. Act. No. 1:08-CV-2930-TWT,

2012 WL 2326115 (N.D. Ga. June 19, 2012). While the present case is factually similar to the *Moore* and *Royal* cases there is one significant variation. There was no live testimony provided by the Petitioner's treating physician; however, there was affidavit testimony along with orders by the treating physicians requiring nursing services.

Federal law requires that under HASCI and other such waivers, the state must spend less per capita than without the waiver. 42 U.S.C. § 1396n(e)(2)(B). The HASCI Waiver Document is clear that there is no individual cost limit. Respondent's Exhibit 2 at 24. Therefore, compliance with the federal law must be reached by looking at aggregate limits. The HASCI Waiver Document limits nursing services to 60 hours per week of LPN or 45 hours per week of RN or a combination of the two not to exceed the equivalent costs of either 60 hours of LPN or 45 hours of RN. The combination of attendant care and nursing care cannot exceed 10 hours per day. Respondent's Exhibit 2 at 1 and 85. The Waiver is not intended to provide around the clock care and the participant must rely, to a certain extent, on care provided by family or friends. T. at 47.

The Petitioner argues that the Waiver limits should not be applied to her based on *Olmstead v. L.C.*, 527 U.S. 581, 119 S.Ct. 2176. *Olmstead* held that the unnecessary institutionalization of individuals with disabilities violates the Americans with Disabilities Act. The Respondent argues that Waiver limits can be applied to the Petitioner based on *Olmstead's* "fundamental alteration" defense. "In evaluating a State's 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.

The Petitioner also cites several additional cases in support of her arguments that Waiver limits should not be applied. She argues that the *Doe* case held that an administrative agency could not apply a rule without promulgating a regulation. However, that holding was specific to the facts of that case in which a state law that was in direct conflict with the policy at issue. In this case, there is no regulation or law which conflicts with the HASCI service limits policy for adults. *Jane Doe v. SCDHHS*, 398 S.C. 62, 727 S.E.2d 605 (SC 2011).

The Petitioner argues that *Peter B. v. Sanford* prevents the Respondent from applying the Waiver reductions. *Peter B. v. Sanford*, 2011 WL 824584 (D.C.S.C. March 7, 2011). However, *Peter B.* granted a preliminary injunction preventing a reduction in Waiver services for the three Plaintiffs in that matter. A preliminary injunction is not a dispositive ruling that the potential reduction violated the ADA or *Olmstead*. It should be noted that, two years later, the matter was dismissed as moot in the case of two of the three plaintiffs due to no actual reduction in their Waiver services. Again, the court did not find that Waiver reductions violated the ADA or *Olmstead*. *Peter B. v. Sanford*, 2013 WL 869607 (D.C.S.C. March 7, 2013).

CONCLUSIONS OF LAW

1. At the time of the appeal, the Petitioner was still hospitalized. The Respondent had denied the service hours ordered by the Petitioner's treating physician and approved a Plan of Care which provided fewer hours. The Petitioner was appealing her dispute over the decreased hours approved by the Respondent in the Plan of Care. One day after discharge, the Petitioner wrote to the Respondent to "reserve all rights." Although the subsequent reductions in service hours which the Petitioner faced were not known at the time of the letter, it is reasonable to assume her request to reserve her rights indicated that she sought continued benefits in the event of future service reductions. The skilled care

medical examination of the Petitioner at any time during the pendency of this appeal. The Petitioner should not have been subject to Waiver limits for skilled care services while under the age of 21 and should have received 28 hours per week of RN and 84 hours per week of LPN as ordered by her treating physician. These hours should have continued through the final result of this appeal.

3. Due to the complicated medical needs and fragile condition of the Petitioner, it appears as though her medical needs could exceed Waiver limits. The Petitioner argues that she should not be subject to the HASCI Waiver limits based on the cases cited above. However, these cases are distinguishable from the present case. The Respondent's September 2012 settlement letter implicitly acknowledges that it may be appropriate to exceed Waiver limits for this particular participant; however, an Administrative Hearing Officer does not have the authority to exceed the limits of the Waiver program. Since reaching the age of 21 and after the conclusion of this appeal, the Petitioner can be subject to Waiver limits and I so order.
4. Should the Petitioner experience a change in circumstances, including a worsening of her condition, she can seek additional service beyond the Waiver limits. Should she experience a service reduction, the Respondent shall provide notice and an opportunity for a hearing.

Issue 3 – How many hours of the authorized care described in #2 above, have been provided by the Petitioner's mother (according to her qualifications), and what is the cost of that care, which amount shall be paid to the Petitioner's mother.

In 2007, SCDDSN Service Coordinator told the Petitioner's mother that SCDDSN rules prohibited the Petitioner's mother from being paid for services she provided to the Petitioner

even though the Petitioner was an adult at this time. The Petitioner's mother should be reimbursed for the number of hours per week that should have been in effect based on continuation of benefits pending the final outcome of the 2007 appeal. The parties failed to provide sufficient evidence for me to determine when the Petitioner was hospitalized and how long each inpatient hospitalization lasted; therefore, I have determined that the Petitioner's mother should be paid for the hours of care provided through the first week in October, 2013 at the rate of \$11.10 per hour. The services she has provided since then until the date of this decision will offset the instances she was not providing attendant care while the Petitioner was hospitalized.

I therefore find:

1. Based on the testimony of both parties, it appears that the Petitioner's mother provided most, if not all, of the uncovered care for the Petitioner from the time she returned home until the present.
2. A family member of a Waiver participant can be paid for authorized hours of attendant care. The Petitioner's mother qualifies as an attendant caregiver.
3. The Petitioner's mother has not been compensated for the care she has provided to the Petitioner.
4. The number of Waiver and State Plan covered hours per week should have amounted to 112 hours as ordered by the Petitioner's treating physician while she was under the age of 21 and protected by the EPSDT provisions of the Medicaid program. This initial amount of ordered care should have continued during the pendency of this appeal.
5. On January 14, 2006, while still hospitalized, the Petitioner turned 18 years of age. As an adult, her parents were no longer legally responsible for her.

6. The Petitioner's mother provided attendant care services to the Petitioner. The parties are in agreement that the current payment rate for Attendant Care is \$11.10.
7. The Petitioner's mother is entitled to reimbursement for the care that she provided as follows:

Hours for Which Petitioner's Mother Shall Be Compensated

Year	Weeks	Hours Res. Should have Provided	Actual Hours Provided by Res.	Hours Provided by S.W.	Weeks x Hours Provided by S.W.	Amount Owed to S.W. at \$11.10 hour
2007	33	112	84	28	924	\$ 10,256.40
2008	27	112	84	28	756	\$ 8,391.60
2008	25	112	80	32	800	\$ 8,880.00
2009	27	112	80	32	864	\$ 9,590.40
2009	25	112	70	42	1050	\$ 11,655.00
2010	52	112	70	42	2184	\$ 24,242.40
2011	52	112	70	42	2184	\$ 24,242.40
2012	52	112	70	42	2184	\$ 24,242.40
2013	40	112	70	42	1680	\$ 18,648.00
TOTAL						\$ 140,148.60

CONCLUSIONS OF LAW

1. At all times during this appeal the Waiver provisions allowed the parents of adult children to serve as paid caregivers to those children according to their training and qualifications (Record of the 2009 Matter at 766.)
2. The rate specified for attendant care providers under the Waiver at all times during this appeal has been \$11.10.
3. The Petitioner's mother shall be reimbursed by the Respondent in the amount of \$140,148.60 for the care that she provided. The Respondent shall reimburse the Petitioner's mother within 30 days of the date of this Order.

Issue 4 – What care is the Petitioner's mother qualified to provide within the authorized hours of service set as described in #2 above and what is the appropriate rate of pay to the Petitioner's mother?

DISCUSSION

Due to the miscommunications described above between the parties, the Petitioner's mother, was not aware that she could be reimbursed for the care that she has provided for the Petitioner. During the Petitioner's lengthy hospital stay, the Petitioner's mother learned to provide suctioning, trach care, and catheter care for the Petitioner. Petitioner's Exhibit 13 at 3. This is skilled level care that only a nurse can provide. Even though the Petitioner's mother does not have any formal medical training, she can provide skilled care for her daughter as a close family member and caregiver. Since the Petitioner's mother has not trained as a nurse, the care she provides is viewed as attendant care services. The parties are in agreement that the Petitioner's mother should be compensated at the attendant care rate of \$11.10 per hour for the services that she provides to the Petitioner when a nurse is not present. I therefore find:

1. The Petitioner's mother is qualified to provide skilled care and attendant care services to B.W. The Petitioner's mother has provided skilled and attendant care during the course of this appeal.
2. The current rate for attendant care providers is currently \$11.10 per hour.
3. The pay rate for attendant care may be subject to change in the future.

CONCLUSIONS OF LAW

1. Petitioner's mother shall be paid at the rate allowed for attendant care providers which is currently \$11.10 per hour.

2. Changes to the pay rate which impact other attendant care providers will also be applied to the Petitioner's mother.
3. Whether the Petitioner's mother must be formally enrolled as a SCDDSN provider is irrelevant to my decision. However, should enrollment be requested by the Respondent in order to ensure timely payment to the Petitioner's mother, the Petitioner's mother shall be afforded all assistance necessary to hasten her enrollment as a SCDDSN provider. Any enrollment process that may be requested shall not prevent the Petitioner's mother from receiving reimbursement for services previously and currently provided.

Issue 5 – What is the cost of an average digital speech device to be paid to the Appellant to defray the cost of the device she purchased?

DISCUSSION

The Petitioner is unable to speak effectively due to injuries to her larynx subsequent to the automobile accident which rendered her quadriplegic. In January 2007, while at MUSC, she was evaluated for a speech generating device and the device was ordered by her physician at the hospital. The device was subject to a prior authorization review by the Medical Director of SCDHHS who found that a less expensive device was appropriate. In March 2007, the Respondent sent a notice that the prior authorization could not be processed stating: "Per our medical consultant, this is not medically necessary or rehabilitative." Petitioner's Exhibit 22. The notice was sent to the durable medical equipment (DME) provider, not the Petitioner. The notice did not state a statute or regulation upon which the decision was based nor did it provide any information regarding the Petitioner's right to appeal the decision. On April 12, 2007, the SCDDSN Service Coordinator wrote to the Petitioner's attorney stating that the HASCI Waiver will pay for assistive technology for the Petitioner once she comes home. Exhibit 3 to

Petitioner's Exhibit 12 (Affidavit of B.W.). On April 24, 2007, Dr. Teresa Cuoco ordered an alternative speech generating device for the Petitioner. On April 25, 2007, Dr. Pamela Pride signed the certificate of medical necessity for this speech generating device. On May 21, 2007, the Respondent notified the DME provider, Dynavox, that the prior authorization request would not be processed. Again, the Respondent informed only the DME provider and not the Petitioner. As with the previous notice, this notice did not state a statute or regulation upon which the decision was rendered nor did the notice provide any information regarding the Petitioner's right to appeal the decision. The Petitioner was under 21 at the time that her treating physicians ordered the speech generating devices and was subject to the protections of EPSDT which allowed her to receive treatment to correct or ameliorate defects and physical illnesses. 42 U.S.C. 1396d(r)(5). According to the Respondent's witness, Ms. Mohamed, the Medicaid program covers speech augmentative devices and covered the particular device that was ordered by the Petitioner's doctor. T. at 119. The entire package of the speech generating device and the covered attachments would have cost the Respondent, "a little over \$8,000." T. at 125. In 2008, after the delays and miscommunications noted above, the Petitioner purchased a speech generating device herself at a cost of \$12,217.70.

The Petitioner testified, via affidavit, that she is frustrated by her inability to communicate which has isolated her and contributed to her depression. Petitioner's Exhibit 12. Ms. Galus, testified that the Petitioner's current speech device requires her to attach a small metal disk to her forehead to use the device. The Petitioner has become allergic to the adhesive used to attach the disk to her forehead. Ms. Galus further testified that the Petitioner is unable to wear her eye glasses when using the device which causes her to suffer migraine headaches. The migraines and the allergies limit the amount of time the Petitioner can use the speech device.

Witnesses for the Petitioner testified that it is possible to obtain speech generating devices which utilize eye gaze technology and do not require an adhesive dot to be attached to the individual's forehead. The Respondent's witness, Ms. Mohammed, testified that there was no set schedule of how often replacement speech devices can be authorized. Authorization of a new device depends on medical necessity. T.at 132. Ms. Wingo, the current Service Coordinator, was also questioned regarding the Petitioner's need for a replacement communication device, to which she responded, "that's outside my scope of job – outside my job description." T at 115.

As the Respondent would have approved a less expensive speech generating device, the Administrative Law Court has determined that the Respondent pay the Petitioner the amount that would have been paid for a digital device in order to defray the cost of the device that the Petitioner purchased. I therefore find:

1. The Petitioner was eligible to receive a speech generating device at the time her doctor ordered it and the Medicaid program covered such devices.
2. A speech generating device and the covered attachments that would have met the Petitioner's needs and her doctor's order would have cost slightly more than \$8,000.00.
3. The Respondent has offered to pay the Petitioner \$8,318.80 to defray the cost of the speech generating device that was purchased by the Petitioner outside of the Medicaid program.
4. The offer of \$8,318.80 is fair based upon the types of devices and attachments covered by the Respondent. This offer is consistent with the cost of such devices and attachments.

CONCLUSIONS OF LAW

1. The Petitioner's mother shall be reimbursed \$8,318.80 to defray the cost of the speech device which she purchased.

2. The Respondent shall reimburse the Petitioner's mother within 30 days of the date of this Order.
3. Whether the cost of the device is covered by the Waiver or by the State Plan is irrelevant to my decision and shall be determined by the Respondent and its agent, SCDDSN. That determination shall not impact or delay the reimbursement of the \$8,318.80 owed to the Petitioner's mother.
4. This Order does not prevent the Petitioner from seeking the difference between the amount awarded here and the actual cost her family incurred. Nor does this Order prevent the Petitioner from seeking an assessment for a new speech generating device or a replacement speech generating device in the future. Should a future medical order for a speech generating device by the Petitioner's provider be denied or reduced by the Respondent, the Respondent shall send the Petitioner notice of such denial or reduction allowing the Petitioner the opportunity to appeal.

DECISION

1. The Petitioner shall receive RN, LPN, and Attendant Care services to the extent allowable under HASCI Waiver limits. She may receive 45 hours per week of RN or 60 hours per week of LPN or a combination of the two not to exceed the costs of RN care. She may combine attendant care with these hours to receive a maximum of 10 hours of nursing and attendant care per day. The Petitioner shall determine the mix of services she shall receive and those hours shall be flexible depending on her needs and the availability of providers in her area. The Service Coordinator shall assist the Petitioner in securing these services.

2. The Petitioner's mother may provide some of the hours of care required under the Petitioner's Service Plan. If the Petitioner's mother provides such care, she shall be paid for that care at the rate for Attendant Care Services (currently \$11.10 per hour).
3. The Petitioner's mother shall be repaid in the amount of \$140,148.60 for the care she provided to the Petitioner during the pendency of this appeal. This amount shall be paid to the Petitioner's mother within 30 days of the date of this Order.
4. Within 30 days of the date of this Order, the Respondent shall reimburse the Petitioner's mother \$8,318.80 for the cost of the speech generating device.

Any issues not addressed in this Order are deemed dismissed.

AND IT IS SO ORDERED.


Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina

November 19, 2013



Nikki Haley GOVERNOR
Anthony Keck DIRECTOR
P.O. Box 8206 • Columbia, SC 29202
www.scdhhs.gov

December 23, 2013

Patricia Harrison, Esquire
611 Holly Street
Columbia SC 29205
VIA CERTIFIED MAIL

Richard G. Hepfer
Deputy General Counsel
South Carolina Department of Health and Human Services
VIA ELECTRONIC DELIVERY

RE: Order in Response to Respondent's Motion for Reconsideration
Matter of Brook Waddle v. SCDHHS
Appeals' Case # 07-MISC-028
Medicaid # 6780499394

Dear Ms. Harrison and Mr. Hepfer:

Enclosed, please find the Order in Response to Respondent's Motion for Reconsideration in the above-referenced matter.

Sincerely,

A handwritten signature in cursive script that reads "Elizabeth B. Hutto".

Elizabeth B. Hutto
Program Director, Division of Appeals and Third Party Liability
Interim CFO, SCDHHS

EBH/ss
Enclosures (2)

RECEIVED

FEB 26 2014

SC Court of Appeals

STATE OF SOUTH CAROLINA	)	BEFORE THE DIVISION OF
	)	APPEALS AND HEARINGS
COUNTY OF RICHLAND	)	SOUTH CAROLINA DEPARTMENT OF
	)	HEALTH AND HUMAN SERVICES
B.W.,	)	
	)	
Petitioner,	)	ORDER
	)	RESPONDENT'S MOTION FOR
-v-	)	RECONSIDERATION
	)	
South Carolina Department of Health	)	
and Human Services,	)	Appeals' Case #: 07-MISC-028
	)	(Remanded)
Respondent.	)	
_____	)	

BACKGROUND

On November 19, 2013, the Final Administrative Decision was issued in this matter. The history of this case was described therein. In response, the Respondent filed a Motion for Reconsideration on December 2, 2013. As of the undersigned date, the Petitioner has failed to respond to the Respondent's Motion.¹ In essence, the Respondent asserts error in the conclusion of law that the Petitioner was entitled to continued benefits at the level that her physicians ordered during the pendency of this appeal. The Respondent makes three requests for relief of the undersigned Hearing Officer as follows:

- "1. Correct the erroneous conclusion of law that when a denial of services is appealed, that the denied services must continue until a decision is rendered on the appeal;
2. Consequently find that, in this case, the appeal, and therefore the requirement to maintain services, did not initially apply to the reductions in services; and
3. Therefore, that under Judge McLeod's directions in this matter that the formally published Waiver limitations (not the ones informally applied by the Departments) should be used to determine the amount of the waiver services that should have been provided since discharge from the hospital."

¹ Note, on December 16, 2013, an email from the Petitioner's Attorney was received by the undersigned Hearing Officer. In that email, the Attorney for the Petitioner explained that, "[M]y assistant of 20 years retired recently and Rick's motion appears to have been misfiled in my office." An email sent two days later clarified that the legal assistant had retired in September.

(Respondent's Motion for Reconsideration at 4)

DISCUSSION

The Respondent asserts that the Final Administrative Decision errs by interpreting 42 C.F.R. § 431.230 as applying to a denial when the language in the regulation speaks only of terminations or reductions of services. I disagree with the assertion that the regulation has been misinterpreted.

In this case, the Petitioner, as advised by her treating physicians stated she needs 112 hours of total care per week. The Respondent, despite not visiting or examining the Petitioner, insisted on fewer hours of skilled care and denied the request for 112 total hours even though this would have been sharply less than the round-the-clock RN hours received during the initial hospitalization that lasted for approximately a year and a half. After many months of delays, the Petitioner was forced to accept the Respondent's proposed hours if she wanted to return home. There was no viable alternative. The Respondent's assertion that this appeal is about a denial of services does not hold up. Clearly, the dispute is over a reduction of services.

In their first request for relief, the Respondent seems to express concern that the asserted misinterpretation of 42 C.F.R. § 431.230 would allow every Medicaid beneficiary who requests a "new service," and who appealed, to receive the service until a hearing decision could be rendered on his request. I believe this concern is misplaced for the reasons stated above. There was never any question that the Petitioner was entitled to, and needed, skilled nursing care. Skilled nursing care was not a "new service" for this Petitioner.

The Respondent's second request that the waiver limits be applied to the Petitioner during the pendency of this appeal cannot be realized due to the Respondent's failure to provide adequate notice of any of the reductions that were applied to the Petitioner. This failure violated the Petitioner's due process rights. When a recipient requests a hearing, the agency may not

terminate or reduce services until a decision is rendered after the hearing unless the agency "promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision." 42 CFR §431.232 (emphasis added). Finally, the hearing must cover "agency decisions regarding the type or amount of services." 42 CFR §431.241 (emphasis added). Even if the Respondent had the discretion to subject the Petitioner to service reductions during the pendency of this appeal, the facts bear out that reductions were executed without prior written notice. These reductions were improper because they violated the Petitioner's due process rights.

The Respondent's third request is based upon an interpretation of the language in the second issue articulated in the July 30, 2012 Remand of the Administrative Law Court. That issue stated:

"The specific type of care and number of weekly hours of each type of care required by the Petitioner during the course of her treatment since her discharge from the hospital in May of 2007 consistent with the Medicaid Program, and the principle that the mother is not legally responsible for caring for the Petitioner."

The Respondent argues that Judge McLeod's language "consistent with the Medicaid Program," means "within the formal waiver limits." I disagree. It seems that had the Administrative Law Judge intended that the formal waiver limits should have applied throughout the appeal, that specific language would have been used. It appears more likely that, "consistent with the Medicaid Program," refers to due process, the delivery of medically necessary services, EPSDT protections, and all other state and federal requirements of Medicaid program.

ORDER

For the foregoing reasons, the Respondent's Request for Reconsideration is hereby denied. The Final Administrative Decision of November 19, 2013 stands.

AND IT IS SO ORDERED.

Elizabeth B. Hutto

Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina

December 23, 2013

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

TELEPHONE (803) 256-2017

FAX (803) 256-2213

February 24, 2014

Jenny Abbott Kitchings, Clerk of Court
The South Carolina Court of Appeals
1015 Sumter Street
Columbia, South Carolina 29201

RE: **Brook Waddle v. SCDHHS**
Case No. 2013-002415

Dear Ms. Kitchings:

Enclosed:

in the above captioned case.

in the stamped envelope provided. Thank you
r.

for y

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South Carolina 29202-8206

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THE STATE OF SOUTH CAROLINA
IN THE STATE OF SOUTH CAROLINA

In the Court of Appeals

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

Case 2013-002415

Brook Waddle Appellant,

v

South Carolina Department of Health and Human Services Respondent.

INITIAL BRIEF OF APPELLANT

Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
803 256 2017
plh.cola@att.net

Kenneth C. Anthony, Jr.
250 Magnolia Street
Spartanburg, South Carolina
864 582 2355

Attorneys for Appellant

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FEB 23 2014
SC Court of Appeals

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II. Statement of Issues on Appeal

1. Do Respondent's longstanding practices of failing to provide notices containing all of the information required by 42 C.F.R. 431.210 and dismissing Medicaid fair hearing appeals without providing evidentiary hearings, for reasons other than those reasons contained in the notices, violate participants' constitutional and statutory rights to due process and the Medicaid Act? Are these violations subject to repetition and have they evaded review?
2. Does the agency's practice of purging the record of evidence fair hearing appellants have submitted violate their constitutional and statutory rights to due process and is this violation is especially egregious when the agency dismisses an appeal without providing the required evidentiary hearing, where it would be required to accept such evidence into the record?
3. Have the Department of Health and Human Services (DHHS) and the Administrative Law Court violated the Separation of Powers Doctrine by obstructing review of Medicaid appeals by the Judicial Branch of government and administering the program based on arbitrary binding norms established by Executive Branch bureaucrats in violation of laws and regulations promulgated by the South Carolina General Assembly and Congress?

III. Statement of the Case

1. Nature of the Case

The parties have widely different views about the nature of this case. Appellant Brook Waddle alleges that this appeal is primarily about ongoing and systemic violations of her right to due process that is guaranteed her under the United States Constitution, the Constitution of the State of South Carolina and the Medicaid Act. Brook complains that DHHS has established a pattern and practice of sending defective notices, or not sending notices at all, and of dismissing fair hearing appeals without providing an evidentiary hearing, based on reasons other than those reasons contained on the notices. She alleges that these constitutional and statutory violations are subject to repetition, but they have evaded review, thereby obstructing her right to judicial review for years. Id.

Respondent views the case far more narrowly. On the one hand Respondent has argued that this case is solely about DHHS' decision to deny payment for an oximeter cable. R. ____.

Instead of supplementing the record of Brook's 2007 appeal (Docket No. 07-ALJ-08-0626-AP), as Brook requested when this subsequent violation occurred, Respondents treated her complaint as a totally new appeal, assigning the case a new number (Case No. 13-MISC-21). This new appeal is hereinafter referred to as "Waddle II." But, then DHHS filed a motion to dismiss the appeal with the Administrative Law Court, appearing to argue that it is part and parcel of Brook's 2007 appeal. The 2007 appeal is referred to herein as "Waddle I." R. ____.

The Administrative Law Court ruled that Brook's complaints about systemic violations of federal and state laws in Waddle I are irrelevant to this appeal. Both the agency and the Administrative Law Court dismissed her appeal without providing an evidentiary hearing.

2. The amount involved in the Appeal

Rule 208 of the South Carolina Rules of Appellate Practice requires the appellant to state the amount involved in the appeal. Because the hearing officer dismissed Brook's request for a hearing without providing the evidentiary hearing required by 42 U.S.C. 1396a(a)(3) and did not allow her to call or cross examine Respondent's witnesses or allow her to submit evidence at the required hearing, the Record does not contain the price of the oximeter cable. Appellant requests that this Court take judicial notice that Medicaid reimbursement rate for the device in our sister state of North Carolina is \$187.21. *See*

http://www.ncdhhs.gov/dma/fee/DME/dme_rates_0114.pdf. Although the device is inexpensive, the failure to use an oximeter can lead to death, thus, the value of this case is actually the value of the life of Brook Waddle. In *People v. Murray*, the conviction of Michael Jackson's personal physician for manslaughter was recently upheld by the California Court of Appeals, in part because the jury found that he failed to use an oximeter to properly monitor Mr. Jackson's vital signs. Case No. B237677 (Cal.Ct.Ap. January 15, 2014). ("According to expert medical testimony presented at trial using a proper pulse oximeter could have saved Mr. Jackson's life." *Id.* at fn 8.)

Instead of monetary damages, in her administrative appeal, Brook has requested nothing more than a declaratory order requiring DHHS to comply with the law and to stop violating the constitutional right to due process of Medicaid participants. Brook also requests that this Court order DHHS to pay reasonable legal fees and costs incurred in this civil action.

3. History of Brook's Medicaid Appeals

a. The April, 2007 Fair Hearing Appeal at DHHS

Brook filed an appeal in 2007 when DHHS refused to pay for the services and equipment her physician determined that she needed upon discharge from MUSC. She requested that all Medicaid services be continued during her 2007 appeal, as required by 42 C.F.R. 431.231. Since her discharge from MUSC in 2007, she has been receiving tracheotomy supplies through Medicaid. Instead of scheduling and holding an evidentiary hearing in 2007, the DHHS hearing officer issued an interlocutory order. R. _____. This order required Brook to submit a "Memorandum of Understanding" and that the Memorandum be in a form and content approved by DHHS. R. _____. But Brook was unable to reach an "understanding" with DHHS and resolution of the appeal was out of her control. R. _____. No such form existed. R. _____. Even though Brook notified the hearing officer that she had tried to comply with her order, instead of scheduling an evidentiary hearing, the hearing officer issued an "Order to Show Cause" on August 17, 2007. This order, issued more than 90 days after Brook filed her request for a fair hearing, required Brook to brief the issues in her appeal before the hearing officer would schedule an evidentiary hearing. R. _____. At this point, approximately 120 days had passed since Brook had requested a fair hearing. On November 16, 2007, the hearing officer issued an order dismissing Brook's fair hearing as "moot," over her objections, without providing the requested evidentiary hearing. 42 C.F.R. 431.244. R. _____.

b. First Appeal to the Administrative Law Court in 2007

Brook appealed the hearing officer's dismissal to the South Carolina Administrative Law Court in 2007. R. _____. In 2009, approximately two years after Brook requested a fair hearing, the Administrative Law Court reversed the agency decision and remanded Brook's appeal back to DHHS, with instructions to provide an evidentiary hearing. R. _____.

c. Fair Hearing Proceedings on First Remand from Administrative Law Court in 2009

The hearing officer held an all day "fair hearing" at DHHS on April 24, 2009 and issued an order on July 9, 2009, upholding the agency's decision to deny the services and equipment her doctor had ordered in 2007. R. _____. Order of DHHS Hearing Officer dated July 9, 2009.

d. Second Appeal to the Administrative Law Court in 2009

Brook filed a second appeal with the Administrative Law Court in 2009. As the appellant, Brook bore the expenses of having the hearing transcribed. Rule 35, Rules of the Administrative Law Court. After briefing, a hearing was held in the South Carolina Administrative Law Court on June 14, 2009 and another hearing held on March 1, 2010, but that Executive Branch Agency (the Administrative Law Court) - on the second trip to that court - did not issue a final administrative order until more than two years later. By that time, more than 1,800 days had passed since Brook filed her request for a final administrative decision requesting that needed medical care be provided with "reasonable promptness." During this time, DHHS improperly reduced Brook's services below the number of hours she was receiving in 2007 when she filed *Waddle I. B. W. v. DHHS*, Case No. 07-MISC-028 (SCDHHS Nov. 19, 2013).

This Court may take judicial notice that in 2012, according to the South Carolina Administrative Law Court's Annual Accountability Report for FY 2011-2012, that Court's "suggested time frame" for disposing of Medicaid appeals was 180 days. *See* http://dc.statelibrary.sc.gov/bitstream/handle/10827/9423/ALC_Annual_Accountability_Report_2011-2012.pdf?sequence=1 at 14. This amount is double the time allowed by federal law to issue a final administrative decision in a Medicaid hearing. 42 C.F.R. 431.244(f) and *Shakhnes v. Berlin*, 689 F.3d 244 (2d Cir. 2012). In FY 2012, the Administrative Law Court only ruled upon 40% of its Medicaid appeals within this 180 day period, taking an average of 284 days to decide Medicaid appeals. 2011-2012 Id. at 15. (This is in addition to the time Medicaid participants spend in the administrative proceedings at DHHS, and it does not take into account any prior appeal to the Administrative Law Court that was remanded back to DHHS.) CMS addressed the issue of delays resulting from remanding fair hearing appeals in the *State Medicaid Manual (SMM)*, which is a manual issued by CMS, the federal agency authorized by Congress to administer the Medicaid program. This Manual "makes available to all State Medicaid agencies ... informational and procedural material needed by the States to administer the Medicaid program.... The manual provides instructions, regulatory citations, and information for implementing provisions of Title XIX of the Social Security Act (the Act). Instructions are official interpretations of the law and regulations, and, as such, are binding on Medicaid State agencies" *Shakhnes v. Berlin*, 689 F.3d 244, fn 11 (2d Cir. 2012). The SMM states that "a

conclusive decision in the name of the State Agency shall be made by the hearing authority” and that a remand “is not a substitute for a definitive and final administrative action.” SMM § 2903.2(A).

Brook filed a motion to reconsider the Administrative Law Court’s decision to remand her case to DHHS and more time passed for a third round of oral arguments to be held in the Administrative Law Court. Appellant’s ALC Brief at 5. Instead of issuing an order that was appealable to the Judicial Branch, on July 30, 2013, the Administrative Law Judge again remanded Brook’s case back to the agency, with instructions to determine:

1. The weekly hours of registered nursing that are needed by the Appellant, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.
2. The specific type of care and the number of weekly hours of each type of care required by the Appellant during the course of her treatment since her discharge from the hospital in May of 2007 consistent with the Medicaid Program, and the principal that the mother is not legally responsible for caring for the Appellant.
3. The number of hours of the authorized care described in #2 above, that have been provided by the mother (according to her qualifications), and the cost of that care, which amount shall be paid to the mother.
4. The amount to be paid for services provided by Brook’s mother, requiring that her mother should be allowed to provide whatever care she is qualified to provide within the authorized hours of service.
5. The cost of an average digital speech device of the type described by Dr. Burton shall be determined and paid to the Appellant to defray the cost of the more expensive device.

R. ____.

e. Second Remand to DHHS in 2012

In October of 2012, an additional two days of evidentiary hearings were held at DHHS on remand from the Administrative Law Court. This hearing was presided over by Honorable Elizabeth Hutto, Esq., who was and is believed to continue to be the Program Director for the

DHHS Office of Appeals and Hearings.¹ On December 10, 2012, approximately 150 days after the most recent remand by the Administrative Law Court back to DHHS, and more than four years after Brook filed her appeal, in December of 2012, Brook filed "Petitioner's Motion for an Interlocutory Order," requesting an interlocutory order requiring DHHS to restore the hours improperly reduced since 2007 (which had been reduced in violation of federal regulations at 42 C.F.R. 431.231 and DHHS' own policies), reimbursement for the speech device in the amount DHHS had already agreed to pay (\$8,318.80) and partial payment to Brook's mother for services she provided for which Judge McLeod determined she was entitled to payment. R. _____. DHHS filed a response objecting to the requested interlocutory order, in part, because "a Final Administrative Decision...is no doubt imminent." R. _____. Yet, nearly a year passed before DHHS issued its order - while Brook's condition continued to deteriorate due to the refusal to provide even the hours she was receiving in 2007 when she filed Waddle I. More than six years after Brook requested a fair hearing complaining that the services her physician had ordered had not been provided with reasonable promptness, DHHS issued a decision on November 19, 2013. R. _____.

f. Appeal of Denial of Tracheotomy Supplies in 2013

In January of 2013, DHHS' agent, KePro sent Brook a notice informing her of the agency's decision to deny payment for an oximeter cable that she needs to measure the oxygen saturation level in her blood. R. _____ and ALC Order dated October 11, 2013 at fn 2. Like the other notices sent by DHHS, this notice did not contain the statute or regulations upon which the DHHS decision was based. Id. 42 C.F.R. 431.210. It also did not inform Brook of the procedure for appealing this denial. Id. Finally, the reason given for denying the prescription of Brook's physician eleven days after Apria submitted it to KePro was "Provider submitted no clinical information supporting request and prescription when requested to do so." Id. There is no evidence in the record that KePro or DHHS made any attempt to contact Brook's physician or to review the extensive medical records in the possession of DHHS to determine the medical

¹ In February of 2013, Ms. Hutto was appointed as the interim Deputy Director and Chief Financial Officer for DHHS, while continuing to hold the position as Program Director for the Office of Hearings and Appeals.

necessity for the device. On January 30, 2013, Brook requested that the record in her Waddle I appeal “be supplemented with this latest denial.” Id.

But, instead of treating this denial as further evidence of the ongoing and systemic violations that Brook complained of in her 2007 appeal, DHHS treated this information as a new and different appeal (referred to herein as “Waddle II”) and assigned it a new case number and hearing officer. R. _____. Instead of scheduling an evidentiary hearing and issuing a decision within 90 days, this new DHHS hearing officer issued a “Pre Hearing Conference Order” which required the parties to confer within one month and imposed a burden on DHHS counsel to file a “summary of issues discussed” and to inform the hearing officer “whether consensus had been reached and any remaining issues.” R. _____. The order required DHHS counsel to provide “with specificity, any additional information that will be submitted at the hearing...” and required Brook’s counsel to attend the conference and to file “a statement of intention to continue the appeal process and to attend a Fair Hearing.” But the order did not address the medical necessity of the device. Id. It did not mention the oximeter cable. Id. Brook’s counsel complied with that order.

On March 19, 2013, Brook’s counsel filed a three page document with the DHHS Office of Hearings and Appeals in response to that order, captioned “Appellant’s Response to Order.” In this Response, she indicated her intent to continue the appeal. R. _____. She incorporated and re-alleged all allegations made since 2007. In this Response, Brook requested reasonable accommodations during the hearing and she requested an independent medical assessment pursuant to 42 C.F.R. 431.240(b). R. _____.² Id. In the letter counsel for DHHS sent to the hearing officer in response to the Pre Hearing Conference Order, the agency admitted that the appeal arose from Apria’s denial of payment for an oximeter cable based on that DHHS provider (not Brook) failing to submit “supporting clinical information” to its agent, KePro. R. _____. Counsel for DHHS deferred to Brook “to allow her to submit to the hearing officer any additional issues

² DHHS paid the amount ordered for the speech device in January of 2013, but has appealed its own agency’s order requiring payment to Brook’s mother for services provided and it has refused to provide the number of hours ordered by the Director of the DHHS Office of Appeals and Hearings, who now also holds the position as Chief Financial Officer of DHHS.

she wishes to raise at the hearing.” Id.

On March 27, 2013, the hearing officer sent an email to counsel complaining that Brook’s Response “does not address the issue of my case (denial of prior authorization of an oximeter cable...)” (Emphasis added.) R. _____. The Pre Hearing Conference Order did not ask Brook to present proof of the medical necessity of the cable. The applicable federal regulations required that Brook be allowed to present testimony at an evidentiary hearing on that issue. 42 C.F.R. 431.242. Federal regulations at 42 C.F.R. 431.244(a) required the hearing officer to base her decision “exclusively on evidence introduced at the hearing.” In the email dated March 27, 2013, the hearing officer demanded that Brook provide her with written “documentation of medical necessity for the cable.” Brook asked in her formal Response that the hearing officer order a medical assessment, to be conducted at agency expense pursuant to 42 C.F.R. 240(b). Id. 42 C.F.R. 431.240(b) requires that this assessment be “obtained at agency expense and made part of the record.”³ Id. On April 4, 2013, the hearing officer issued an order dismissing Brook’s request for a fair hearing without providing an evidentiary hearing, concluding that Brook had somehow “abandoned the appeal...” by not providing written proof of medical necessity for the cable prior to a hearing being scheduled. R. _____.

g. Third Appeal to the Administrative Law Court in 2013

On May 9, 2013, Brook filed an appeal with the South Carolina Administrative Law Court of the dismissal of Waddle II, which had been dismissed by the DHHS hearing officer on the grounds of “abandonment.” Brook objected to the failure to provide an evidentiary hearing and the failure of the hearing officer to include in the Record on Appeal records of the 2007 appeal, which Brook had incorporated by reference in her Response to the hearing officer’s Pre Hearing Order.⁴ R. _____. In Issue 2 of Appellant’s Initial Brief filed with the Administrative Law

³ 42 C.F.R. 431.250(f) provides for federal matching funding for assessments authorized pursuant to 42 C.F.R. 431.240(b). The federal match in South Carolina is approximately 70%

⁴ It appears that the Administrative Law Court may have been under pressure to dispose of Medicaid cases more promptly than in the past. This Court may take judicial notice and compare that Court’s 2012-2013 Accountability Report to the prior year’s report, which shows that the average number of days to resolve a Medicaid appeal had increased from 284 days in FY 2011-2012 to 422 days by the following year. See

Court, Brook complained that:

DHHS and this Court, as agencies of the executive branch of state government, have violated the separation of powers provision of the South Carolina Constitution, Brook's Constitutional right to due process, her statutory right to notices of the denial, reduction or termination of Medicaid services meeting the requirements of 42 C.F.R. 431.210, her right to an evidentiary hearing meeting the requirements of 42 C.F.R. 431.242 and 244 and her right to a final administrative decision within 90 days of her April 28, 2007 appeal by failing to rule upon all of the issues raised in her 2007 appeal and delaying her opportunity for judicial review for more than six years.

On page 19 of Appellant's Initial Brief, Brook alleged:

The State Medicaid Agency has failed to provide an evidentiary hearing when her requests for services have been denied, in violation of 42 C.F.R. 431.220. DHHS and this Court have limited and interfered with her freedom to make a request for a hearing in violation of 42 C.F.R. 431.221. In clear violation of 42 C.F.R. 431.223, DHHS has dismissed Brook's requests for an evidentiary hearing. It has denied her procedural rights to an evidentiary hearing as established in 42 C.F.R. 431.242. (Emphasis added.)

Instead of simply providing this inexpensive device that is needed to measure Brook's oxygen saturation level, DHHS filed a Motion to Dismiss Brook's appeal with the South Carolina Administrative Law Court on September 11, 2013. R. _____. In this motion, DHHS asked the Administrative Law Court to dismiss Waddle II because her claim "is precisely or substantially the same in both proceedings."⁵ R. _____. Motion to Dismiss at 3. At that point,

<http://www.scalc.net/pub/FY2012-2013%20ALC%20Accountability%20Report.pdf>
http://dc.statelibrary.sc.gov/bitstream/handle/10827/12038/ALC_Annual_Accountability_Report_2012-2013.pdf?sequence=1 at 15. The number of Medicaid appeals had nearly doubled, increasing from 15 to 27 in just one year. Whereas in FY 2011-2012 forty percent of cases were resolved within the Court's own "objective" of 180 days between filing and disposition, a year later, only 23% of Medicaid appeals were being decided by the Administrative Law Court within 180 days. (These numbers do not include the time between the Medicaid participant filing her appeal with DHHS and the case being filed in the Administrative Law Court, nor are they believed to include prior appeals to the Administrative Law Court which were remanded back to DHHS). Dismissing Medicaid appeals, without providing a hearing, might have helped improve these statistics.

⁵ The November 19, 2014 order of the hearing officer in Waddle I did not mention the denial of the oximeter cable.

DHHS agreed with Brook that the violations complained of in Waddle II were “encompassed in the complaint” filed in 2007. Id. at 4. (“Therefore, Appellant’s appeal should be dismissed pursuant to Rule 12(b)(8) because the claims are precisely or substantially the same in both proceedings.” Id.)

h. DHHS Offer to Settle in 2013

While Waddle I and II were pending, in September of 2012, DHHS offered to settle Brook’s appeals by providing fewer hours than her physicians ordered since 2007, but more hours than are allowed by the current caps imposed on DDSN Medicaid waiver participants. November 19, 2013 Order at 10. But this offer would require Brook to abandon her challenge of the validity of the 2010 reductions, thus leaving her in worse shape than she was in when she filed her appeal in 2007. DHHS’ offer would restore the number of hours of services nearly to the level she was receiving in 2007, but would not provide the number of hours her physicians ordered now or in the future.

I. Administrative Law Court Order on 2013 Appeal (Waddle II)

On October 11, 2013, without providing a hearing in the Administrative Law Court, the Administrative Law Judge issued an order dismissing Waddle II. He found that the hearing officer erred in ruling that Brook had abandoned her appeal. Despite both parties now arguing that the denial of the oximeter cable was included in the appeal that had been pending since 2007, the Administrative Law Judge concluded that “the oximeter cable is a new claim that has not been raised in other, pending proceedings.” R. _____. His order dismissed Brook’s appeal (Waddle II) on different grounds, i.e. that Brook “failed to challenge the hearing officer’s decision in her Initial Brief.” Id.

j. Appeal of 2013 Administrative Proceedings to South Carolina Court of Appeals

Brook received the Administrative Law Court’s order dismissing her 2013 appeal (Waddle II) on October 15, 2013 and she filed and served a timely notice of appeal with the South Carolina Court of Appeals on November 12, 2014.

k. Third DHHS Order on 2007 Administrative Appeal (Waddle I)

Back at DHHS, on November 19, 2013, the hearing officer assigned to Waddle I (the action filed in 2007) issued an order on the 2007 administrative appeal. This decision confirmed

that DHHS had repeatedly over a period of years violated Brook's due process rights and that DHHS had improperly reduced her services during the appeal. R. _____. November 19, 2013 Order. The hearing officer ordered DHHS to provide the number of hours Brook's physician had ordered in 2007 during the pendency of her state administrative appeal, ordered DHHS to pay her mother for services that Medicaid should have paid and to reimburse Brook for a speech device that should have been provided in 2007. Id.

However, the hearing officer ruled that the Office of Appeals and Hearings does not have the authority to order DHHS to exceed the caps contained in the waiver document. R. _____. However, according to this order, the agency (DHHS) has the authority to exceed waiver limits "for this particular participant," at its discretion:

The Respondent's September 2012 settlement letter implicitly acknowledges that it may be appropriate to exceed Waiver limits for this particular participant; however, *an Administrative Hearing Officer does not have the authority to exceed the limits of the Waiver program.* (Emphasis added.)

Order dated November 19, 2013 at 31. This Court may take judicial notice that in *Peter B. v. Sanford*, 6:10-cv-00767-JMC -BHH, Report and Recommendation of Magistrate Judge dated November 24, 2010 (S.C.D.C. 2011) and in *Richard Stogsdill v. Sebelius*, Case No. 3:12-0007-TMC (SCDC), DHHS has argued that federal courts do not have jurisdiction over lawsuits brought by DDSN Medicaid waiver participants contesting the validity of these caps. DHHS has argued to those federal courts that the state administrative "fair hearing" proceedings are the sole remedy available. DHHS has also argued to the federal district court judge and the United States Court of Appeals for the Fourth Circuit in *Doe v. Kidd I and II* that the state administrative appeal process is the only remedy for Medicaid waiver participants who object to violations of federal law in the administration of Medicaid programs in South Carolina. *Supra*.

I. Third Appeal to the Administrative Law Court of the 2007 Appeal in 2013

Brook appealed the decision of the hearing officer, i.e. the decision that the hearing officer does not have the authority to exceed the caps imposed in 2010 (without authorization of the General Assembly or promulgation of regulations) to the South Carolina Administrative Law

Court in December of 2013.⁶ R. _____. If she had not filed this appeal, her services would have immediately been reduced below the amount her physicians and the hearing officer found to be inadequate to meet her needs.

Upon receipt of this November 19, 2013 order, HHS filed a motion to reconsider its own hearing officer's order in Waddle I and the hearing officer issued another order on December 23, 2013, affirming that the November 19, 2013 order was her "final order." R. ____ and _____. When the hearing officer issued the December 23, 2013 order on DHHS' motion to reconsider the November 19, 2013 order of the DHHS hearing officer, DHHS then filed an appeal of its own agency's final order with the South Carolina Administrative Law Court. ____ and _____.

m. Current Status

Brook requested additional time to file her brief in this Court after the issuance of the DHHS hearing officer's decision, hoping to negotiate a resolution. R. _____. That request was granted by this Court. R. _____. Unfortunately, the parties were unable to settle either appeal. The hearing officer, who had been promoted to the position of Chief Financial Officer for DHHS in February of 2013, while continuing to hold the position as Director of the Office of Hearings and Appeals, filed a request with the Administrative Law Court requesting an additional eight weeks to file the Record on Appeal in Waddle I. R. _____. The Administrative Law Court granted that motion to delay filing the transcript and the date for filing the Record on Appeal in Waddle I has been extended to April 3, 2014, nearly seven years after Brook filed her appeal and requested that medically necessary services be provided with "reasonable promptness." R. _____.

4. Proceedings in the lower court.

Rule 208 requires appellants to include in the Statement of the Case the proceedings in the lower court that have affected the appeal or may throw light upon the questions involved in the appeal. The pleadings the parties have filed and the orders of the agency and the lower court are included in Brook's Designation of the Record.

IV. Standard of Review

The standard of review in this case is governed by the Administrative Procedures Act.

⁶ Brook also alleges that a mathematical error was made in the calculation of the amount owed to Brook's mother for services she provided. R. _____.

S.C. Code Ann. § 1-23-380(5) (Supp.2010). *Jane Doe v. DHSS*, S.E.2d 605, 398 S.C. 62, 71 (S.C. 2011). This Court may affirm the agency's decision, remand the matter, or 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 granted 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.

Id. Brook seeks injunctive relief and a declaratory judgment in this action, not money damages. Declaratory judgments, in and of themselves, are neither legal nor equitable. *See Felts v. Richland County*, 303 S.C. 354, 356, 400 S.E.2d 781, 782 (1991). The standard of review for a declaratory judgment action is determined by the nature of the underlying issue. "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 equitable actions, the appellate court may review the record and make findings of fact in accordance with its own view of a preponderance of the evidence. *Shaw at 492. See also Ingram v. Kasey's Assocs.*, 340 S.C. 98, 105, 531 S.E.2d 287, 290-91 (2000); *Townes Assocs. v. City of Greenville*, 266 S.C. 81, 85, 221 S.E.2d 773, 776 (1976).

The court may substitute its judgment for that of the agency on issues of law. *Mullis v. the South Carolina Department of Health and Human Services*, 04 ALJ 30-0194-AP (2005). While construction of a statute by an agency is accorded the "most respectful consideration," the final responsibility for the interpretation of the law rests with the Court. *Id.* "An agency's mistaken interpretation of a statute or regulation will constitute reversible error of law." *Id.* A reviewing court may reverse an agency's final decision as arbitrary if the decision is without rational basis, is based alone on one's will and not upon a course of reasoning and exercise of

judgment, is made at pleasure, without adequate determining principles, or is governed by no fixed rules or standards. *Id.* An abuse of discretion occurs where the deciding judge bases his decision on an error of law without evidentiary support. *Id.* at 475.

Statutory interpretation is a question of law that is subject to *de novo* review. *Town of Summerville v. City of N. Charleston*, 378 S.C. 107, 110, 662 S.E.2d 40, 41 (2008) (citation omitted). "The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature." *Media Gen. Commc'ns, Inc. v. S.C. Dep't of Revenue*, 388 S.C. 138, 147-48, 694 S.E.2d 525, 529 (2010) (quoting *Charleston Cnty. Sch. Dist. v. State Budget & Control Bd.*, 313 S.C. 1, 5, 437 S.E.2d 6, 8 (1993)). "If the statute is ambiguous ... courts must construe the terms of the statute." *Town of Mt. Pleasant v. Roberts*, 393 S.C. 332, 342, 713 S.E.2d 278, 283 (2011) (citation omitted). But, where the statute's language is plain, unambiguous, and conveys a clear, definite meaning, the rules of statutory interpretation are not needed and the court has no right to impose another meaning. *Gay v. Ariail*, 381 S.C. 341, 345, 673 S.E.2d 418, 420 (2009).

V. Background

1. The Medicaid Program

Medicaid is a federally funded program through which the federal government "provides financial assistance to states so that they may furnish medical care to needy individuals." *Jane Doe v. DHHS*, 398 S.C. 62, 727 S.E.2d 605 (S.C. 2011). Participation in the program is voluntary; however, participating states must comply with requirements imposed by the Medicaid Act and related regulations. *Wilder v. Virginia Hosp. Assoc.*, 496 U.S. 498, 502, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). ("Although North Carolina may retain a special sovereignty interest in choosing whether to participate in the Medicaid program, once it elects to participate, it is not entitled to assert that interest to insulate itself from the requirements of the federal program."), cert. denied, *Odom v. Antrican*, 537 U.S. 973 (2002). To receive federal funding, a state must submit and have approved a "plan for medical assistance" that describes the nature and scope of the state's Medicaid program. *Id.* A state's plan must provide covered medical services with reasonable promptness to all Medicaid beneficiaries for whom they are medically necessary. See 42 U.S.C. § 1396a(a)(1), (a)(10)(A)(I), (a)(10)(B) (2006); *Doe v. Kidd I*, 501 F.3d 348, 354 (4th Cir. 2007) and *Doe v. Kidd II*, Case No. 10-1191 (4th Cir. March 24, 2011). When

DHHS denies, reduces or terminates services, or fails to provide services with reasonable promptness, DHHS is obligated to provide a evidentiary hearing meeting all of the due process requirements of *Goldberg v. Kelly*, 397 U.S. 254, 261(1970). 42 U.S.C. 1396a(a)(3) and 42 C.F.R. 431.200 et. seq.

In S.C. Code Ann. § 44-6-730, the South Carolina General Assembly directed DHHS to “promulgate regulations as are necessary for the implementation of this article and as are necessary to comply with federal law. In addition, the commission shall amend the state Medicaid plan in a manner that is consistent with this article.” S.C. Code Ann. (Emphasis added.) S.C. Code Ann. § 44-6-190 requires DHHS to promulgate regulations pursuant to the Administrative Procedures Act and directs that appeals from decisions by the department are heard pursuant to the Administrative Procedures Act, Administrative Law Judge, Article 5, Chapter 23 of Title 1 of the 1976 Code.

Agency policy is contained in the DHHS website which sets forth “Appeals and Hearings Frequently Asked Questions” at <https://www.scdhhs.gov/site-page/appeals-and-hearings-frequently-asked-questions> This web page informs the public that the DHHS hearing officer “will decide whether the action proposed or taken by the South Carolina Department of Health and Human Services is correct and fair” and it informs the public that the hearing is “a court-like procedure conducted by a hearing officer of the Division of Appeals and Hearings.” DHHS explains that;

The hearing officer listens to your explanation of why you do not agree with the action taken by the South Carolina Department of Health and Human Services. The hearing officer will also listen to the South Carolina Department of Health and Human Services' explanation of the action taken on your case. Both sides can ask questions of any witnesses. The hearing officer will ask questions to get enough information to decide if your case was handled correctly, based on the current regulations and policies.

In keeping with 42 C.F.R. 431.210, this web page correctly states that the notice must contain the following information:

- (1) A statement of the proposed action
- (2) The reason for the proposed action
- (3) The regulation or policy that supports the action (see Regulations and Policy Links)
- (4) An explanation of your right to a fair hearing

(5) An explanation of how you can continue to receive benefits during the appeal process. This policy informs appellants that they must provide DHHS prior notice if they intend to be represented by an attorney at the hearing. (But DHHS does not impose this requirement to notify the appellant that an attorney will represent the department at the hearing.) According to this policy, appellants are informed that if they “withdraw or abandon” an appeal, their benefits will be discontinued. This policy describes “an Interlocutory Order” as is “a document sent to you and/or the South Carolina Department of Health and Human Services requesting additional action(s) or information.” DHHS informs appellants in this policy that DHHS may require them to attend a pre hearing conference and that if they do not respond to the Interlocutory Order by the due date, the hearing officer has the authority to dismiss the appeal. Appellants are also informed that a notice of hearing will be mailed at least 30 days before the hearing date. DHHS instructs appellants that DHHS may submit a brief, but that “Even if you do not give the hearing officer a brief, you can still make arguments, call witnesses, and submit documents at the hearing.” Evidence allowed into the record includes medical records, or school records” and “a letter from your doctor.”⁷ Documents may be submitted before or at the hearing. According to this agency policy, participants will be allowed to make an opening statement, present arguments and evidence, cross-examine the other party's witnesses and to present a closing statement. The fact sheet does not mention the requirement that DHHS issue a decision within 90 days, or that it must provide services with “reasonable promptness” (interpreted by the courts as meaning no later than 90 days).

When a Medicaid participant files a request for a fair hearing, it is the policy of DHHS to continue providing services on appeal until a final administrative ruling is issued by the Administrative Law Court. R. _____. Order dated Nov. 19, 2003 Order at 31. (“According to Dr. Veldheer, if a participant requests continuation of services, those services are continued through the Administrative Law Court level.” Id. at 26.) See also Affidavit of Byron Roberts, general counsel for DHHS attached to Brook’s December 10, 2012 Motion for an Interlocutory Order,

⁷ But this Court may take notice that DHHS has argued that sworn affidavits of health care providers should not be considered by hearing officers or considered as evidence, because they are “hearsay.” R. ____.

which states:

...if the DHHS Hearing Officer denies a Medicaid Waiver appeal, and the service recipient appeals that decision to the South Carolina Administrative Law Court, DHHS has a longstanding practice of keeping the services in effect during the pendency of the Administrative Law Court. Rule 34 of the Administrative Law Court Rules provides for an automatic stay of agency action during the pendency of an appeal to the ALC unless a party requests otherwise, but DHHS does not, as a practice, ask that the automatic stay be lifted in appeals involving service eligibility issues. This has been true for the administrative appeals...generally.

R. ____.

In addition to "regular," or "State Plan" Medicaid benefits, the State provides Medicaid Home and Community Based services through the Head and Spinal Cord Injury (HASCI) program administered by the South Carolina Department of Disabilities and Special Needs (DDSN) under contract with DHHS. S.C. Code Ann. 44-38-310. This program was created by 42 U.S.C. § 1396n© (2000), allowing states to waive the requirement that persons with disabilities live in an institution in order to receive certain Medicaid services. *Doe v. Kidd I*, 501 F.3d 348, 351 (4th Cir. 2007). The Medicaid waver program enables states to receive federal financial assistance specifically to provide medical care for needy individuals who would otherwise require institutional care. *Id.*

Prior to 2010, DHHS did not have caps on DDSN Medicaid waiver services, but drastic reductions were implemented on January 1, 2010, with caps imposed on the number of hours provided in the home. *Peter B. v. Sanford*, 6:10-cv-00767-JMC -BHH, Report and Recommendation of Magistrate Judge dated November 24, 2010 (S.C.D.C. 2011). R. ____.

Those caps were reversed by the Administrative Law Court in every known case in which the Medicaid waiver participant had a lawsuit pending in federal court when the Administrative Law Court issued its decision. When many of these "parallel track" waiver participants filed requests for an administrative hearing at DHHS, an "interlocutory order" was issued and their appeals were dismissed by the DHHS hearing officers without providing evidentiary hearings required by 42 U.S.C. 1396a(a)(3). Yet, while these administrative appeals were pending, after dismissal of their "fair hearing appeal" without providing an evidentiary hearing, DHHS continued to argue to the federal district court judges that the administrative appeal process was the sole remedy available to Medicaid participants and that the federal courts do not have jurisdiction to consider

complaints involving violations of the Medicaid Act. *Peter B. v. Sanford, supra., Hickey v. Forkner*, Docket No. 10-ALJ-08-0650AP (SCALC July 19, 2011).

In *Hickey v. DHHS*, the DHHS hearing officer dismissed the individual's fair appeal without providing an evidentiary hearing in 2010. R. _____. The South Carolina Administrative Law Court ruled that the DHHS hearing officer violated the participant's due process rights by dismissing Hickey's appeal without providing an evidentiary hearing and that the 2010 caps could not be enforced, because they established binding norms without promulgating regulations. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0650AP (SCALC July 19, 2011). In *Hickey v. Forkner* the federal district court issued an order prohibiting DHHS from applying the 2010 caps to reduce Hickey's services, allowing her to continue to receive 50 hours a week of PCA services - which is 22 hours a week over the cap established in 2010 by DHHS. Case No. 4:10-2696-TWL-TER (SCDC December 21, 2011). The federal court held that DHHS had improperly treated the 28 hour a week cap as a "binding and enforceable rule without promulgating the cap as a regulation pursuant to the Administrative Procedures Act." *Id.* The federal district court reported that DHHS informed the Court that it had no plan to promulgate the caps as a regulation. *Id.* DHHS has continued to treat these caps as binding norms for other Medicaid participants, in complete disregard for the ruling of the Administrative Law Court in *Hickey*.

The Administrative Law Court likewise, ruled that DHHS committed legal error by dismissing appeals in other cases based on Medicaid participant's responses to "interlocutory orders" without providing evidentiary hearings required by 42 U.S.C. 1396a(a)(3) in *Edge v. DHHS*, Docket No. 10-ALJ-08-0501-AP (SCALC October 29, 2010); *Eubanks v. DHHS*, Docket No. 10-ALJ-08-0502-AP (SCALC October 29, 2010); *Morgan v. DHHS*; Docket No. 10-ALJ-08-0503-AP (SCALC October 29, 2010).⁸ Yet, this same practice continues without corrective

⁸ In an order that conflicts with *Hickey*, in *Richard Stogsdill v. DHHS*, the hearing officer upheld the 2010 caps, despite DHHS having previously determined, in 2009, that more hours were medically necessary. R. _____ and _____. (Orders of DHHS hearing officer and the Administrative Law Court in *Richard Stogsdill*). *Richard Stogsdill's* case is on appeal to this Court, with oral arguments scheduled for March 12, 2014. S.C. Court of Appeals Case No. 10-ALJ-0774-AP. The cuts were also recently upheld by the Administrative Law Court in *Myers v. DHHS*, 11-MISC-302(MR/RD) (SCDHHS February 9, 2012), in another order that contradicts *Hickey*. As in *Brook's* case, in *Myers*, the hearing officer first dismissed his case without

action in *Waddle II* and other cases.

In *Peter B. v. Sanford*, the district court granted the plaintiff's motion for a preliminary injunction, prohibiting DHHS from imposing the 2010 caps on Michelle M. and Chip E., which had not been promulgated as regulation. Case No. 6:10-767-TMC (D.S.C. March 7, 2013). R. _____. The South Carolina Administrative Court, adopted the holding in *Hickey*, ruling that the caps on DDSN Medicaid waiver services were unenforceable against Michelle M. and Chip E. *Eubanks v. DHHS*, Docket No. 10-ALJ-08-0502-AP (SCALC October 29, 2010); *Morgan v. DHHS*, Docket No. 10-ALJ-08-0503-AP (SCALC October 29, 2010). Yet DDSN and DHHS continue to enforce the caps against those Medicaid participants like Brook who have not yet filed federal lawsuits.⁹

providing a hearing, based on Myers responses to an "interlocutory order" that were unsatisfactory to the hearing officer. *Id.* On remand from the Administrative Law Court, the hearing officer upheld the reductions. Myers' case was frozen in the Executive Branch for four years before an opportunity for judicial review was made available to Myers on February 3, 2014, when the Administrative Law Court issued an order upholding the reductions. *Myers v. DHHS*, Docket No. 12-ALJ-08-0713-AP (SCALC Feb. 3, 2014). R. _____.

⁹ Subsequently, the federal district court dismissed the lawsuits brought by Chip E. and Michelle M., because they prevailed in their administrative appeals and DHHS assured the court that the caps would not be enforced against them. R. _____. *Peter B. v. Buschemi*, Case No. 6:10-767-TMC (D.S.C. 2012). Their attempt to appeal this interlocutory order was denied by the Court of Appeals for the Fourth Circuit, because the federal district court judge stayed the claims of the third plaintiff, Peter B., pending resolution of his state administrative appeal. The South Carolina Court of Appeals had remanded Peter's case to DHHS with instructions to provide a fair hearing "in accordance with this opinion and pursuant to 42 C.F.R. § 431.220(a)(1)-(2)." *Brown v. DHHS*, 393 S.C. 11, 709 S.E.2d 701 (S.C.App. 2011). But, in violation of that order of the South Carolina Court of Appeals, the DHHS hearing officer dismissed Peter's appeal again two years later, without providing a hearing on the merits of his case. *Peter Brown v. DHHS* (SCDHHS March 12, 2013). See also *Peter Brown v. DHHS*, Docket No. 13-ALJ-08-0159-AP (SCALC Feb. 4, 2014). The Administrative Law Court upheld that dismissal, over the objections of Peter's guardian in February, 2013. In *Peter Brown v. DHHS*, and in *Richard Stogsdill v. DHHS*, the DHHS Office of Appeals and Hearings purged from the record on appeal the testimony and evidence presented in the evidentiary hearings held in 2006 (Brown) and 2009 (Stogsdill). DHHS has not imposed the 2010 caps on Richard Stogsdill, solely because he has a pending lawsuit in the federal district court, and his services continue pending resolution of his federal case. The district court dismissed Stogsdill's claim against the federal government, allowing his private action against state actors to proceed. *Richard Stogsdill v. Sebelius*, No. 12-

The “comparability statute” of the Medicaid Act requires that services and eligibility requirements provided to one member of a covered group must be made available to all participants in that program. 42 U.S.C. § 1396a(a)(10)(B)(I), (ii). Services provided to any individual in a group of covered persons must be “equal in amount, duration, and scope for all recipients within the group.” 42 C.F.R. § 440.240. Courts have consistently recognized that states have violated the comparability requirement when some recipients are treated differently from other recipients in cases where each has the same level of need. *Schott v. Olszewski*, 401 F.3d 682, 688-89 (6th Cir.2005) (finding treatment was not comparable when Medicaid did not reimburse recipient for medical expenses she paid out of pocket after she was wrongfully denied coverage); *White v. Beal*, 555 F.2d 1146, 1151-52 (3d Cir.1977) (finding statute was illegal when it covered eyeglasses for those suffering from eye diseases but did not cover glasses for patients when refractive error caused poor eyesight).

Section 1320c, et seq. of the Social Security Act requires the creation of a peer review system developed through disinterested “Quality Improvement Organizations (QIO’s).” Quality Improvement Organizations review the activities of health professionals in the area “for the purpose of determining whether... the quality of such services meets professionally recognized standards of health care[.]” 42 U.S.C. § 1320c-3(a)(1)(B). QIO’s must “apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice within the geographic area served by the organization as principal points of evaluation and review, taking into consideration national norms where appropriate.” *Id.* at § 1320c-3(a)(6)(A). DHHS has contracted with KePro to provide QIO reviews. Because DHHS refused to provide an evidentiary hearing, where Brook could have called KePro and DHHS witnesses to testify, this Court should take judicial notice of DHHS’ website that announced its contract with KePro as its chosen “Quality Improvement Organization.”¹⁰ See

7, D. S.C.; 2013 U.S. Dist. LEXIS 18062 (S.C.D.C. Feb. 11, 2013).

¹⁰ The notice does not state whether Apria is a Managed Care Organization (MCO) and it does not advise Brook about how she can initiate an appeal. If Apria is a Managed Care Organization, the time frame for resolving her appeal is significantly reduced. 42 C.F.R. 431.244(f) provides that a decision must be issued “as expeditiously as the enrollee’s health

<https://www.scdhhs.gov/sites/default/files/QIOMedicaidBulletin.pdf>. According to its website at [/www.kepro.com/services/independent-medical-reviews.aspx](http://www.kepro.com/services/independent-medical-reviews.aspx), KePro is:

...dedicated to assuring that members are not unfairly denied medically necessary services. Our appeals are performed by independent, objective peer reviewers much like us who know the ropes. KEPRO performs fee-for-service and managed care appeals.

In Waddle II, there is no evidence of any review being conducted by peer reviewers at KePro before the DHHS hearing officer dismissed her appeal, over Brook's objections, without providing a fair hearing. The process KePro is supposed to follow was discussed in *In the Matter of Protests of Carolinas Center for Medical Excellence et al*, Case Nos. 2011-114, 115 and 116 (Richland County Chief Procurement Officer, June 21, 2011).

2. History of Brook's Medicaid Services

Upon discharge from the hospital in 2007, DHHS provided some services at home through both "regular" Medicaid and the HASCI program, pursuant to Brook's plan of care that DDSN approved. But DHHS denied Brook's request for payment for the number of hours and durable medical equipment that had been determined by her treating physician to be medically necessary. R. ___. November 19, 2013 Order. As the hearing officer recognized in her December 23, 2013 order, even though these services were inadequate to meet Brook's needs at home:

After many months of delays, the Petitioner was forced to accept Respondent's proposed hours if she wanted to return home. There was no viable alternative.

R. ___. DHHS also refused to pay for the speech device that had been ordered by two physicians. Id.

Brook is unable to move her arms or her legs, she breathes through a tracheotomy and

condition requires, but no later than 3 working days after the agency receives, from the MCO or PIHP..." 42 C.F.R. 438.410 contains rules for the resolution of expedited appeals:

(a) General rule. Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

suffers from grand mal seizures. R. ____ and ____ Id. at 1 and 15. She is fed by an attendant. She is afflicted by spastic quadriplegia, a neurogenic bladder, hypothyroidism, dysphagia, and hypotension. She has a history of pulmonary embolus and staff infections, including MRSA. Id. at 18 and 19. She has been hospitalized with confusion and an altered mental state and suffers from depression and anxiety. Id. at 18.

Brook must be suctioned throughout the day to clear mucus from her tracheotomy tube which “could be deadly ...” Id. at 14. Since returning home, Brook has suffered frequent bouts of pneumonia which require suctioning as frequently as three to five times an hour. Id. Brook requires catheterization and a bowel program and has suffered from frequent urinary tract infections and painful kidney stones. Id. at 15. Brook cannot feel when she is wet, causing her skin to break down. Id. Id. She has a history of decubitus ulcers and must be turned once or twice every two hours to prevent skin breakdown. Id. She needs, but is not receiving, physical therapy and occupational therapy to improve contractures which prevent her from straightening her arms. Id. Her skin breaks when her arms are stretched. Id. Brook takes daily medications for seizures, depression, neuropathy pain, prevention of muscle and bladder spasms and for migraine headaches. Id.

Waddle I has lingered in the Executive Branch for nearly seven years without a decision that is appealable to the Judicial Branch. More than 2,500 days have passed since Brook filed her 2007 administrative appeal complaining that DHHS was refusing to provide medically necessary services and equipment with reasonable promptness. Brook identified the following issues in her 2007 appeal:

1. The State’s failure to provide Brook with services in the least restrictive setting, including, but not limited to, nursing services, attendant services, psychological services, assistive technology devices and other services for which appellant is eligible to receive. (Emphasis added.)
2. The State has failed to provide medically necessary services with “reasonable promptness.”
3. The State erred in denying requested services in violation of applicable federal case law and regulations.

R. _____. In Waddle II, Brook alleged that DHHS' denial of the oximeter cable violated her right to due process and rights under the Medicaid Act. She has alleged that this action constituted evidence of continued violations of federal law that were appealed in Waddle I.

Brook testified at the 2012 hearing (through an affidavit, because she was unable to attend the hearing) that she would "rather die than go to a SCDDSN Regional Center like Whitten Center or to attend a workshop..." November 19, 2013 Order at 21. Ms. Hutto's order in Waddle I that was issued on November 19, 2013 determined that community based treatment is appropriate for Brook and that she requires "constant care and cannot be left alone." Id at 21 and 24. According to that order, Brook has not received the RN services that she needs. Id. The hearing officer ruled that Brook "should receive the maximum services available under the HASCI Waiver." Id. According to the order of the DHHS hearing officer in Waddle I, Brook has been "maintained at home with fewer services than those to which she was entitled due to the extraordinary efforts and dedication of her mother." Id. at 25.

In one denial notice sent in 2007, DHHS informed Brook that the number of hours ordered by her physician exceeded HASCI limits. But this rule was contradicted in testimony from agency witnesses in Waddle I, because prior to 2008, DHHS did not impose caps on HASCI services. Id. at 7 and 9. In another notice, DHHS informed Brook that her request for services was being denied, because the cost would exceed the cost of nursing home care. R. _____. But, as the DHHS hearing officer stated in the November 19, 2013 order, according to testimony at Brook's 2012 fair hearing, "The HASCI Waiver Document is clear that there is no individual cost limit." According to the testimony of the director of the HASCI program, DDSN was following "limits we were applying at the direction of HHS," but no regulations were ever promulgated allowing either agency to limit Medicaid waiver services and no documentation of the basis for those limits appears in the record. Id. at 7.

In 2010, without promulgating regulations or obtaining approval of any kind from the South Carolina General Assembly, DHHS implemented "across the board" cuts in Medicaid waiver services. *Peter B. v. Sanford, supra.* and *Hickey v. Forkner, supra.* The hearing officer noted in the November 29, 2013 order that these reductions were implemented without providing an "individual assessment to determine whether the cuts were appropriate..." Id. at 10.

According to the current Chief Financial Officer for DHHS (hearing officer Hutto), no cost analysis was performed by DHHS to determine if less expensive services could be used and no medical review of the consequences of the cuts was performed by DHHS or DDSN. Id.

The DHHS hearing officer found that the notices DDSN issued to Brook in Waddle I “were improper as they did not contain the statutes or regulations the actions were based upon nor did they provide instruction on how to appeal the negative action.” Id. at 22. The November 19, 2013 order states that “the reasons for the denials given in these notices were erroneous according to the testimony of the Respondent.” Id. The hearing officer determined that Brook’s services were “improperly reduced several times” while her appeal was pending and that these reductions “occurred without notice and the opportunity to appeal.” Id. She ruled that DHHS improperly reduced Brook’s services in 2008 without providing the required notice. Id. The order states that DHHS again “improperly reduced” Brook’s hours in 2009 while her appeal was pending and that DHHS again “failed to provide proper notice.” Id. The order states that DHHS erred by failing to reassess her need for services when her parents divorced and her mother became Brook’s sole family caregiver. Id. at 23. She found that the DDSN service coordinator erroneously asserted that Brook was restricted to receiving two hours a day of RN services. Id. Because of “miscommunication and service reductions,” according to that order, Brook’s mother has provided all of the care that DHHS improperly failed to provide. Id.

Also according to the November 19, 2013 Order, prior to 2010, there was no evidence that the State conducted medical reviews of Brook’s condition to determine the number of hours of care that she requires. R. _____. Id. at 16. DHHS has not “provided any records which indicate that a physician for the Respondent has ever reviewed the Petitioner’s medical needs.” Id. at 24. Since 2010, a “centralized nurse” conducts an assessment to determine medical necessity, but this DDSN nurse has never met Brook nor been to her home. Id. at 16 and 17. The “centralized nurse” does not give any deference to physicians’ orders that exceed the caps DDSN has imposed. Id. The State failed to present any medical witnesses with “direct knowledge” of Brook’s condition at any of the hearings. DHHS’ medical director, Dr. Burton, was “somewhat familiar” with Brook’s case, but he never met Brook before the day he testified and he has no training in head or spinal cord injuries and he admitted that he was only “vaguely familiar” with

the HASCI program. Id. Dr. Burton admitted at the 2009 hearing that he did not have expertise to override the orders of a treating physician. Id. His decision to deny services was based upon “Department guidance and the SCDHHS provider manual policy.” Id.

Even though the DHHS hearing officer ruled at page 25 that Brook’s benefits “should have continued at the levels ordered by her treating physician during the pendency of this appeal,” in violation of DHHS’ policy, those services were repeatedly reduced and Brook has remained a captive in the Executive Branch Medicaid Appeal Gulag.

VI. **Arguments**

1. **Do Respondent’s longstanding practices of failing to provide notices containing all of the information required by 42 C.F.R. 431.210 and dismissing Medicaid fair hearing appeals without providing evidentiary hearings, for reasons other than those reasons contained in the notices, violate participants’ constitutional and statutory rights to due process and the Medicaid Act? Are these violations subject to repetition and have they evaded review?**
- a. **The lower court’s decision to deny payment for the oximeter cable should be reversed by this Court, because the DHHS notice was defective.**

In January, 2013, DHHS, through its agent, KePro, sent Brook a notice informing her of its decision to deny payment for an oximeter cable that she needs to measure the oxygen level in her blood. R. _____. It is clear on the face of the notice that it did not contain the statute or regulations relied upon - in violation of the clear and simple mandate contained in 42 C.F.R. 431.210. The notice also did not inform Book about how she might obtain a hearing. The reason given for denying the oximeter cable was that “Provider submitted no clinical information supporting request and prescription when requested to do so.” R. _____. There is no evidence that this decision to deny funding for an oximeter cable was based on the opinion of a physician or that KePro of DHHS reviewed the voluminous medical records available to DHHS or that any physician or nurse was consulted before denying payment for this inexpensive but life saving equipment.

The “fair hearing” notice requirements contained at 42 C.F.R. 431.210 are unambiguous and they are mandatory. The Supremacy Clause of the United States Constitution requires that DHHS comply with these regulations instead of the conflicting policies adopted by DHHS. The federal regulation at 42 C.F.R. 431.210 requires DHHS to provide in its notices of denial,

reduction or termination of Medicaid benefits both “the reasons for the intended action” and “the specific regulations that support, or the change in Federal or State law that requires, the action.”

There can be no doubt but that the South Carolina General Assembly directed DHHS to comply with federal law in providing notices to Medicaid participants. S.C. Code. Regs. § 126-380.

Denial, Termination, or Reduction of Benefits requires that:

A. When an individual's Medicaid benefits are denied, discontinued or changed, the individual shall receive notice pursuant to Title XIX of the Social Security Act. The notice shall include an explanation of the individual's right to a fair hearing, the method to obtain a hearing, and the right to representation.

42 C.F.R. 431.210(b) and (c).

The notice DHHS' agent, KePro, sent to Brook denying payment for an oximeter cable was clearly and plainly defective, because it did not contain the specific information required by 42 C.F.R. 431.210. It was legal error to deny payment for the oximeter cable based on this notice. This is a common practice for DHHS to ignore this federal notice mandate and Medicaid participants, including Brook, will continue to suffer unless this Court holds DHHS accountable for this violation and enjoins the agency from violating the law in the future, with appropriate consequences for contempt.

42 C.F.R. § 431.244(d) is meaningless if DHHS can notify the participant of one reason in the notice, then proceed to dismiss an appeal for a different reason not specifically allowed by the applicable federal rules. The “reason” KePro provided for denying payment for the oximeter cable Brook needed was that one of DHHS' providers failed to meet the agency's timeliness standards. The notice stated that KePro, had not received information it had requested from DHHS' provider, Apria, within 48 hours. R. 14. This “notice” did not even address or consider Brook's need for the equipment or the consequences of not receiving it. But, the hearing officer dismissed Brook's appeal based on reasons that were totally different from those reasons contained in the notice, which is a violation of 42 C.F.R. 431. 210. The actual reason the hearing officer used as grounds to dismiss Brook's appeal are that Brook did not comply to her satisfaction with an email she sent on March 27, 2013. That is not an allowable reason for dismissing an appeal and it was not included as grounds for dismissal in KePro's notice.

The federal regulations require DHHS to explain the circumstances under which a

hearing will be granted and how to continue benefits if an appeal is requested. 42 C.F.R. 431.210(d). The notice KePro sent on January 9, 2013 does not contain this information and it is facially deficient. DHHS should not be allowed to terminate a supply as important as an oximeter cable based on a defective notice that did not inform Brook of how she could continue to receive tracheotomy supplies while she fought the appeal.

Dismissing Brook's appeal on grounds not included in the notice directly conflicts with the federal regulation at 42 C.F.R. 431.223 which sets forth only two very limited grounds for dismissing an appeal (1) where the participant requests dismissal in writing, and (2) where the appellant fails to appear at a hearing without good cause. Not only did the hearing officer and the lower court allow the agency to violate 42 C.F.R. 210, the notice requirement, but their decision is in direct conflict with 42 C.F.R. 431.223. This violation of unambiguous requirement that the notice contain the reasons for the denial prejudiced Brook and violated her constitutional right to due process.

- b. **By dismissing Brook's appeal without providing a hearing, DHHS illegally denied her right of due process to be heard on her claims that DHHS had violated the Americans with Disabilities Act and the reasonable promptness mandate of the Medicaid Act.**

By dismissing Brook's appeal without providing an evidentiary hearing on her complaints, the hearing officer violated Brook's due process rights by failing to address or rule upon Brook's allegations that DHHS had violated the Americans with Disabilities Act. (Yet in the federal courts, DHHS argues that this is Brook's sole venue for addressing violations of the ADA.) The Hearing Officer failed to respond to Brook's allegations contained in "Appellant's Response to Order" alleging that the reductions in her services during the administrative appeals process violated agency policy and that DHHS had failed to rule upon her "emergency motion" that she had filed in December 2012.¹¹ R. _____. Brook alleged in her Response that the agency's

¹¹ At the hearing in 2012, DHHS argued that the reductions in services that occurred without notice in 2008 and 2009 were not properly before the hearing officer, because Brook had not filed new appeals addressing those reductions. Yet, when she raised this issue in what DHHS considered to be a new appeal in 2013, the hearing officer did not even address her complaint that DHHS had failed to act upon her request with reasonable promptness.

refusal to comply with the July 2010 order of the Administrative Law Court, the ADA and the Medicaid Act constituted “conscious indifference of DHHS and its officials to risks of harm to Appellant and the decline in her medical and psychological condition.” R. at _____. The hearing officer also ignored Brook’s requests that DHHS provide reasonable accommodations to allow her to participate in the fair hearing appeal. Id. She requested adaptive equipment that would allow her to participate in the hearing, which is required by the ADA, but the hearing officer ignored this request also by simply not scheduling a hearing. Id.

The hearing officer also ignored Brook’s request for an independent medical assessment. Instead, the hearing officer illegally shifted the burden to Brook to provide a medical assessment, not just at the hearing, but to provide proof of medical necessity even before she would schedule a hearing. This is a clear violation of the mandate of the United States Supreme Court in *Goldberg v. Kelly*, 397 U.S. 254 (1970), which is specifically incorporated into the Medicaid regulations. 42 C.F.R. 431.202(b). The hearing officer exceeded her authority under the statute, these regulations and *Goldberg* by requiring written proof before scheduling a hearing and her decision was arbitrary and capricious and it was intended to harm Brook and to protect the agency.

These violations of Brook’s due process rights have been repetitive, as is evident from the November 19, 2013 order, as well as dismissed appeals of Brown, Hickey, Edge, Eubanks, and Morgan. Brook and other vulnerable and powerless waiver participants have been prejudiced and they are likely to be subjected to these illegal acts again in the future and this Court should issue a strong rebuke by this Court and an order enjoining these Executive Branch agencies from future violations.

- c. **The hearing officer’s decision to dismiss Brook’s appeal without providing an evidentiary hearing must be reversed, because it violated the Supremacy Clause of the United States Constitution and Doe’s right to due process.**

42 U.S.C. 1396a(a)(3) is unambiguous and it requires the State:

...to provide for granting an opportunity for a fair hearing before the State agency [responsible for the Medicaid program] to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness," §

1396a(a)(3).

Doe v. Kidd I, 501 F.3d 348, 357 (4th Cir. 2007). The due process standards which are set forth in *Goldberg v. Kelly*, and cited in the federal Medicaid regulations at 42 C.F.R. 431.202(d), require that " *the decisionmaker's conclusion* ... must rest solely on the legal rules and evidence adduced at the hearing," and that " *the decision maker should state the reasons for his determination and indicate the evidence he relied on.* " *Goldberg*, 397 U.S. at 271.

The hearing officer erred as a matter of law in interpreting S.C. Code Ann. Regs. 126-154 as preempting federal law. The hearing officer's interpretation, i.e. that this state regulation allows a Department of Health and Human Services hearing officer to dismiss a Medicaid participant's administrative appeal without providing an evidentiary hearing is just plain wrong.¹² This was legal error because this state regulation is preempted under the Supremacy Clause of the United States Constitution by 42 U.S.C. 1396a(a)(3) of the Medicaid Act, which states that a State Plan for medical assistance must - (3) "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." In relying upon this state regulation that is preempted by federal law, the hearing officer and the Administrative Law Court failed to consider another DHHS regulation which correctly recognizes that federal Medicaid laws and regulations are controlling in this case and all Medicaid appeals. DHHS Regulation § 126-399, which is titled "Conflict Between State and Federal Regulations," provides that:

When the requirements of the State and the Federal regulations are not in agreement, the requirements of the Federal regulations shall prevail.

Federal law clearly and unambiguously required the hearing officer to base her decision

exclusively on evidence presented at an evidentiary hearing. 42 C.F.R. 431.244(a) provides that:

Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing.

¹² The hearing officer's "Findings of Fact" erroneously state that Petitioner's attorney failed to return a response to the "Pre Hearing Conference Order," thereby abandoning Brook's appeal. R. at 2 But, in response to that "Pre Hearing Conference Order," Brook's counsel filed and served a three page response on March 19, 2013. R. ____.

When a hearing officer fails to provide a fair hearing, it is impossible for her decision to be based exclusively on evidence presented at a hearing. As this Court has recognized, 42 C.F.R. 431.220(a) requires that “the State agency must grant an opportunity for a hearing to ...(1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness, and (2) Any recipient who requests it because he or she believes that the agency has taken an action erroneously.” (Emphasis added.) *Brown v. DHHS*, 303 S.C. 11, 709 S.E.2d 701, 705 (S.C.App. 2011). (“Accordingly, the remainder of the order is vacated, and the case is remanded to DHHS for a hearing on the merits in accordance with this opinion and pursuant to 42 C.F.R. § 431.220(a)(1)-(2).”).¹³ Granting a hearing is mandatory, not optional...the federal regulations say “must,” not “may.”

The decision of the hearing officer and the lower court also ignores the mandate of federal law contained at 42 C.F.R. 431.205, which states that the Medicaid agency “must be responsible for maintaining a hearing system that meets the requirements of this subpart.” (Emphasis added.) That subpart requires that the State’s hearing system must provide for a hearing and that the hearing system “must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in this subpart.” In *Goldberg*, the United States Supreme Court ruled that the Due Process Clause of the Fourteenth Amendment to the United States Constitution requires an evidentiary hearing before government benefits can be terminated. The Court held that the appellant is not entitled to a trial, but she is entitled to an oral hearing before an impartial decision-maker, the right to confront and cross-examine witnesses, and the right to a written opinion that sets out the evidence relied upon and the legal basis for the decision. In *Goldberg*, as in Brook’s case, the government agency argued that allowing an appellant the opportunity to provide a written statement to “demonstrate why his grant should not be discontinued or suspended,” without providing an evidentiary hearing met the requirements of due process. *Id.* at 258. But, in declaring that procedure to be

¹³ But two years later, DHHS once again dismissed Brown’s appeal, over his objections, without providing an evidentiary hearing. *Brown v. DHHS*, (SCDHHS 2013) and (SCALC 2014). R. ____ and ____.

unconstitutional, the Supreme Court ruled that when "welfare is discontinued, only a pre-termination evidentiary hearing provides the recipient with procedural due process." *Id.* at 264. Brook was denied the right to a pre-termination hearing before funding for her tracheotomy supply, i.e. an oximeter cable, was denied.

As was the case with the plaintiffs in *Goldberg*, Brook "lacks independent resources" and her "situation becomes immediately desperate" when her benefits are reduced. *Id.* In *Goldberg*, the Supreme Court recognized that the welfare participant's "need to concentrate upon finding the means for daily subsistence, in turn, adversely affects his ability to seek redress from the welfare bureaucracy." *Id.* In dismissing Brook's appeal without providing the evidentiary hearing required by *Goldberg* and 42 C.F.R. 431.205, the lower court erred as a matter of law in failing to recognize that:

Public assistance, then, is not mere charity, but a means to "promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity." The same governmental interests that counsel the provision of welfare, counsel as well its uninterrupted provision to those eligible to receive it; pre-termination evidentiary hearings are indispensable to that end.

Id. at 265. As a hearing officer for the State Medicaid Agency, Ms. Johnson is charged with knowledge of the requirements of *Goldberg*, in which the Supreme Court directed:

It is not enough that a welfare recipient may present his position to the decisionmaker in writing or second-hand through his caseworker. Written submissions are an unrealistic option for most recipients, who lack the educational attainment necessary to write effectively and who cannot obtain professional assistance. Moreover, written submissions do not afford the flexibility of oral presentations; they do not permit the recipient to mold his argument to the issues the decisionmaker appears to regard as important. Particularly where credibility and veracity are at issue, as they must be in many termination proceedings, written submissions are a wholly unsatisfactory basis for decision. The second-hand presentation to the decisionmaker by the caseworker has its own deficiencies; since the caseworker usually gathers the facts upon which the charge of ineligibility rests, the presentation of the recipient's side of the controversy cannot safely be left to him. Therefore, a recipient must be allowed to state his position orally.

(Emphasis added.) The directive contained in 42 U.S.C. 431.244(a) comes directly from the directive of the United States Supreme Court in *Goldberg* that provides:

Finally, the decisionmaker's conclusion as to a recipient's eligibility must rest solely on the legal rules and evidence adduced at the hearing. *Ohio Bell Tel. Co. v. PUC*, 301 U.S. 292 (1937); *United States v. Abilene & S. R. Co.*, 265 U.S. 274, 288-289 (1924). To demonstrate compliance with this elementary requirement, the decisionmaker should state the reasons for his determination and indicate the evidence he relied on, cf. *Wichita R. & Light Co. v. PUC*, 260 U.S. 48, 57-59 (1922).

The hearing officer's March 27, 2013 email required Brook, after she had filed a three page response to the hearing officer's Pre Hearing Order, to prove to her in writing, before a hearing was even scheduled, that the oximeter cable was medically necessary. Brook had already responded to this hearing officer's "interlocutory order," by advising the hearing officer that she intended to participate in a fair hearing and that it would be legal error to dismiss her appeal, citing 42 C.F.R. 431. "unless the appellant requests dismissal or fails to appear at a scheduled hearing without good cause." R. _____. She requested that the hearing officer order an independent medical assessment and provide the hearing she was entitled to receive.

The hearing officer's decision to ignore this controlling Supreme Court case and the applicable federal statute and regulations was at very best arbitrary and capricious. In no uncertain terms, the Supreme Court directed government benefits agencies in *Goldberg* that: "Welfare recipients must therefore be given an opportunity to confront and cross-examine the witnesses relied on by the department." The facts that this is the second time a DHHS hearing officer has dismissed Brook's appeal complaining about DHHS' denial of services, without providing an evidentiary hearing, and the fact that this practice appears to be routine for the agency (as will be discussed in the issue addressing the violation of the Separation of Powers Doctrine) underscores the importance of a strong rebuke by this Court and an order requiring the Executive Branch agencies involved to comply with the United States Constitution and the requirements set forth by the United States Supreme Court in *Goldberg*.

The Supremacy Clause of the United States Constitution clearly preempts state regulations and requires DHHS and the lower court to comply with federal law. Instead, DHHS has repeatedly violated the clear requirements of 42 U.S.C. 1396a(a)(3) and CMS regulations contained at 42 C.F.R. 431.200 et seq. and their decisions must be reversed.

By dismissing Brook's appeal without providing an evidentiary hearing, the agency and

the lower court also violated the Fourteenth Amendment of the United States Constitution, which prohibits the States from depriving any person of life, liberty, or property, without due process of law. As the Administrative Law Court recognized in *Mullis I*: “Due process of law is one of the most important guarantees found in the United States Constitution.”¹⁴ *Supra*. Pursuant to Article I, Section 22 of the South Carolina Constitution. In *Mullis v. DHHS I*, DHHS terminated Mullis’ certification as a provider of DDSN waiver services in violation of her due process rights for two years before her eligibility was restored. 04 ALJ 30-0194-AP, Order dated March 22, 2005. R.

_____. In *Mullis*, the Court determined that the guarantee of due process contained in the Fourteenth Amendment of the Federal constitution prohibits the State from depriving any person of “life liberty or property, without due process of law.” *Mullis* at 10 or 15. Due process guarantees “basic fairness before a tribunal for all citizens.” *Id*. Fundamental to due process is the opportunity to be heard “at a meaningful time and in a meaningful manner.” *Mullis* at 10, citing *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965). But, as in Brook’s case, DHHS repeated this illegal process against Mullis several years later in complete disregard for the prior findings of the South Carolina Administrative Law Court in *Mullis v. DHHS II*, 10-ALJ-08-0775 (S.C.A.L.C. April 23, 2012). In the 2012 appeal, the Administrative Law Court again held that DHHS’ wrongful termination of Mullis’ contract was arbitrary and capricious, an abuse of discretion and that it was clearly erroneous in light of the reliable, probative and substantial evidence in the record.

In addition to the agencies violating the federal Constitutional rights of Appellant, SCDDSN has violated the state constitutional due process rights granted to Appellant in Article I, Section 22 of the South Carolina Constitution which provides:

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 subject to the same person for both prosecution and adjudication; 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.

¹⁴ The patterns and practices of DHHS which violate the basic tenants of due process are found not only in the many cases DHHS has improperly dismissed without a hearing, but in two cases involving a provider of DDSN services whose due process rights were violated multiple times, without any attempt to correct the agency’s illegal practices. In *Mullis v. DHHS I*, DHHS improperly terminated her status as a provider of services in violation of her due process rights. 10-ALJ-08-0775 (S.C.A.L.C. April 23, 2012).

(Emphasis added.) This provision is specifically aimed at Administrative agencies such as DHHS. Lowell et.al, *South Carolina Administrative Practice and Procedure*, 2004 at page 47. In this case, substantial rights of Brook have been prejudiced by the agency's repeated violation of her constitutional and statutory due process rights to an evidentiary hearing before an impartial decision maker. S.C. Code Ann. § 1-23-380(5) (Supp.2010). Brook requests an injunctive order reversing the decision of the lower court and prohibiting DHHS from terminating any services or funding for durable medical equipment without providing an evidentiary hearing on the merits of her case. Brook requests an order reversing the decision of the agency and the lower court and requiring DHHS on all future appeals to comply with the due process requirements set forth herein. Brook requests an order finding that she is the prevailing party on this issue.

2. **Does the agency's practice of purging the record of evidence fair hearing appellants have submitted violate their constitutional and statutory rights to due process and is this violation is especially egregious when the agency dismisses an appeal without providing the required evidentiary hearing, where it would be required to accept such evidence into the record?**

Brook was prejudiced when the hearing officer dismissed her appeal and submitted an incomplete Record on Appeal to the Administrative Law Court. Brook requested in her Response to Hearing Officer Johnson's interlocutory order that allegations made "in the course of these proceedings and the appeal filed in 2007" be included in the record and those documents should have been included in the Record on Appeal. But, instead of providing an evidentiary hearing at which she would be allowed to submit this evidence of past wrongful acts, patterns of violation of due process and other testimony and evidence, as required by 42 C.F.R. 431.220, 431.240 and 431.244, the hearing officer dismissed her appeal and refused to include those documents in the Record on Appeal. The hearing officer purged Brook's carefully compiled record and did not include any of the testimony, pleadings and evidence that Brook had established at great cost during the six years she had spent in State Administrative Appeals Siberia. This practice of purging the record has been used by DHHS in other cases where DHHS refuses to include in subsequent Records on Appeal to the Administrative Law Court any of the evidence compiled before remand by the previous Administrative Law Court decisions. *Stogsdill v. DHHS* and *Brown v. DHHS, supra*. This is especially prejudicial to poor and disabled citizens like Brook who do not have funds to pay doctors and other health care providers to make repeated appearances or to prepare multiple declarations or affidavits on the same issue.

Medicaid participants are entitled to rely upon 42 U.S.C. 1396a(a)(3) and the regulations interpreting that act so that they do not end up at the Administrative Law Court with an inadequate record because the DHHS hearing officer violated the law and denied their right to introduce evidence and testimony at a hearing. 42 C.F.R. 431.244(b)(2) requires DHHS to include in the record "all papers and requests filed in the proceeding." South Carolina Rules of the Administrative Law Court require the agency to include in the Record on Appeal "All pleadings, motions, and intermediate rulings; all evidence received or considered; all proffers of proof of excluded evidence and the transcript of the testimony taken during the proceeding." By short circuiting this process, DHHS has violated Brook's right to have a complete record.

3. **Have the Department of Health and Human Services (DHHS) and the Administrative Law Court violated the Separation of Powers Doctrine by obstructing review of Medicaid appeals by the Judicial Branch of government and administering the program based on arbitrary binding norms established by DHHS bureaucrats in violation of laws and regulations promulgated by the South Carolina General Assembly and Congress?**

The South Carolina Constitution provides in S.C. Const. art. I, § 8 that : "In the government of this State, the legislative, executive, and judicial powers of the government shall be forever separate and distinct from each other, and no person or persons exercising the functions of one of said departments shall assume or discharge the duties of any other." In this case, the Executive Branch was required by federal law to issue a final order within 90 days of Brook's request for a fair hearing, after which the affected participant may seek judicial review. 42 C.F.R. 431.244(f), *Shakhnes v. Berlin*, No. 11-2003-cv (2d Cir. August 13, 2012) and *Doe v. Kidd I*, 501 F.3d 348 (4th Cir. 2007). The mandate that Congress imposed on the States to issue final decisions with "reasonable promptness" gives the Executive Branch 90 days to fix their errors. 42 U.S.C. 1396a(a)(3) and 42 C.F.R. 431.244(f), 42 C.F.R. 435.911. After that time, Medicaid participants are entitled to petition the Judicial Branch to review wrongful acts taken by the Executive Branch in administering the Medicaid program. This is especially important where life and death matters - like tracheotomy supplies - are at issue and a delay of years might result in death for want of an inexpensive device denied by DHHS.

DHHS and the Administrative Law Court, both agencies within the Executive Branch, have repeatedly violated the reasonable promptness standard of the Medicaid Act and they have attempted to prevent the Judicial Branch from reviewing their wrongful acts against the most needy, fragile, and vulnerable citizens of South Carolina. *Doe v. DHHS, supra* and *Brown v. DHHS, supra*. Through this system of delays and remands - administrative law keep away - persons like Brook may die before they reach the door of the court house.

As the South Carolina Supreme Court recently held:

The preservation of a separation of powers has been a basic tenet of democratic societies at least since Baron de Montesquieu warned that "[t]here would be an end of everything, were the same man or the same body, whether of the nobles or of the people, to exercise those three powers, that of enacting laws, that of executing the public resolutions, and of trying the causes of individuals." See Montesquieu, *The Spirit of Laws* 152 (Thomas Nugent trans. 1949). Consistent with this notion, the South Carolina Constitution requires the branches of government be "forever separate and distinct from each other, and no person or persons exercising the functions of one of said departments shall assume or discharge the duties of any other." S.C. Const. art. I, § 8.

South Carolina Public Interest Foundation and Sloan v. South Carolina Transportation Infrastructure Bank, 27266 (SCSC June 12, 2013). As the Court recognized in that case:

"One of the prime reasons for separation of powers is the desirability of spreading out the authority for the operation of the government." *State ex rel. McLeod v. Yonce*, 274 S.C. 81, 84, 261 S.E.2d 303, 304 (1979). "The legislative department makes the laws[,] the executive department carries the laws into effect, and the judicial department interprets and declares the laws." *Id.* at 84, 261 S.E.2d at 305. This delineation of powers amongst the branches "prevents the concentration of power in the hands of too few, and provides a system of checks and balances." *State ex rel. McLeod v. McInnis*, 278 S.C. 307, 312, 295 S.E.2d 633, 636 (1982).

In this case, these Executive Branch agencies have ignored both federal and state law and the intentions of Congress and the General Assembly. They have failed, or even refused, to promulgate regulations whereby the Legislative Branch would have an opportunity to review their procedures and policies and the public would have an opportunity to have input at public hearings.

Brook has been denied judicial review by the Executive Branch of government by these agencies' practice of cycling and recycling her case between state agencies by misusing the power of remand. The Executive Branch has totally ignored Brook's Constitutional and statutory right of due process and a final determination which must be issued within 90 days of the request for a fair hearing pursuant to federal regulations. *Doe v. Kidd I*, 501 F.3d 308 at fn 3. (4th Cir. 2007). These agencies have ignored 42 C.F.R. 435.930, which requires the State to "furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures." They have ignored the State's assurances made to CMS that "safeguards necessary to protect the health and welfare of recipients" will be provided. 42 C.F.R. 441.353.

42 C.F.R. 431.202(d) clearly provides that "The hearing system must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional

standards specified in this subpart.” But Brook has been denied, until now, the ability to have judicial review of these violations. DHHS and DDSN have violated the separation of powers prohibition by failing to promulgate regulations, as required by the South Carolina Administrative Procedures Act and by reducing, denying and terminating her services based on binding norms established by the agencies without promulgating regulations. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0650AP (SCALC July 19, 2011); *Edge v. DHHS*, Docket No. 10-ALJ-08-0501-AP (SCALC October 29, 2010); *Eubanks v. DHHS*, Docket No. 10-ALJ-08-0502-AP (SCALC October 29, 2010); *Morgan v. DHHS*, Docket No. 10-ALJ-08-0503-AP (SCALC October 29, 2010).

The Preemption Clause of the United States Constitution prohibits DHHS from dismissing Brook’s appeal without providing a fair hearing meeting the requirements of *Goldberg* and 42 C.F.R. 431.200 et. seq. and judicial review of agency actions. The United States Supreme Court recently addressed the issue of a State Medicaid Agency’s violation of the Preemption Clause of the United States Constitution. In *Wos v. E.M.A.*, North Carolina’s Medicaid Agency attempted to enforce a state Medicaid lien statute which conflicted with the anti-lien provisions of the Medicaid Act. 568 U.S. ___, (U.S. Supreme Court March 20, 2013). Justice Kennedy wrote in his majority opinion that “Where state and federal law ‘directly conflict’ state law must give way.” Affirming the decision of the Fourth Circuit, the Supreme Court ruled in *Wos* that:

Preemption is not a matter of semantics. A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute’s intended operational effect.

That is exactly what the Executive Branch of government has done in Brook’s case. Many of the provisions of the Medicaid Act are quite complicated and difficult to understand. The Act has been described as “an aggravated assault on the English language, resistant to attempts to understand it.” *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981). But, the requirements to provide a notice that meets the statutory provisions of 431.210 and the simple requirement to give every Medicaid participant who requests one a fair hearing and a final administrative decision within 90 days is not in any way complicated or difficult to understand.

42 C.F.R. 431.244(f) means something. According to the South Carolina Administrative Law Court’s Annual Accountability Report for FY 2011-2012, that Court’s “suggested time frame” for disposing of Medicaid appeals was 180 days, double the time CMS allows for a State to issue a final administrative appeal decision. See http://dc.statelibrary.sc.gov/bitstream/handle/10827/9423/ALC_Annual_Accountability_Report_2011-2012.pdf?sequence=1 at 14. 42 C.F.R. 431.244(f) and *Shakhnes v. Berlin*, 689 F.3d 244 (2d

Cir. 2012). That year, the Administrative Law Court only ruled upon 40% of its Medicaid appeals within this 180 day period, taking an average of 284 days to decide Medicaid appeals, not counting the time spent in proceedings at DHHS or earlier proceedings in the Administrative Law Court on the same issue. 2011-2012 Id. at 15. By the next year, the average length of time to decide a Medicaid appeal had increased to 422 days and only 23 percent of the Medicaid appeals were decided within 180 days. See Accountability Report for FY 2012-2013 at <http://www.scalc.net/pub/FY2012-2013%20ALC%20Accountability%20Report.pdf>. These numbers do not even include the number of days in DHHS “fair hearing” proceedings or in prior appeals of the same case to the Administrative Law Court.

CMS has addressed the use of remands to drag out administrative proceedings in the State Medicaid Manual (SMM), which contains CMS’ official interpretations of the law and regulations. This manual is binding on Medicaid State agencies and the Administrative Law Court. *Shakhnes v. Berlin*, 689 F.3d 244, fn 11 (2d Cir. 2012). The SMM states that “a conclusive decision in the name of the State Agency shall be made by the hearing authority” and that a remand “is not a substitute for a definitive and final administrative action.” SMM § 2903.2(A). Yet, these agencies have a long history of dragging out administrative appeals for years, flat out ignoring the reasonable promptness mandate, refusing to grant hearings on the merits and dismissing fair hearing appeals based on agency policy without complying with 42 U.S.C. 1396a(a)(3) or the unambiguous requirements set forth in 42 C.F.R. 431.424 and 244.

Brook prays for this Court to issue an order finding that the Medicaid “fair hearing” process violates the Separation of Powers Doctrine because it obstructs the timely review of denials of DHHS by the Judicial Branch and the reasonable promptness requirements of the Medicaid Act. The Executive Branch simply cannot comply with the mandates of federal law, which requires a final administrative decision to be issued within 90 days, under the current scheme. The current process requires the Medicaid participant to file an appeal with DHHS, which must provide at least 30 days notice prior to the evidentiary hearing required by 42 U.S.C. 1396a(a)(3). The agency has completely ignored 42 C.F.R. 431.244(f) by further delaying decisions through the issuance of “interlocutory orders” that violate *Goldberg* by requiring written proof instead of an evidentiary hearing. DHHS has flaunted its violations of Congress’ reasonable promptness mandate. Once the appellant reaches the Administrative Law Court, another Executive Branch agency, she must wait for DHHS to provide the Record on Appeal, which sometimes takes months. Then each side is allowed thirty days to file briefs with the Administrative Law Court and notice must be provided before a hearing can be held in that Court. Despite federal regulations which prohibit the Executive Branch from using remands to

delay a final decision, that is standard process in Medicaid appeals and Medicaid participants get sicker by the day, requiring more expensive treatment when their basic medical needs are ignored by the agency that has assured CMS that it will protect the health and welfare of Medicaid waiver participants.

This is a matter of extreme public importance. In order to qualify for Medicaid, in the DDSN Medicaid waiver programs in South Carolina, the participant cannot own more than \$2,000 in liquid assets. For every participant who makes it through the Herculean hurdles imposed by DHHS, then the Administrative Law Court there is a multitude of the most vulnerable citizens of our State who have no access to justice and no ability to navigate their way through the Executive Branch to the Courts of this State. Due process requires that these persons have access to the Judicial Branch. Not only do their lives hang in the balance, but taxpayers of this State are paying for expensive hospitalizations and institutionalization because Executive Branch agencies are denying funding for medically necessary services, like a simple oximeter.

VII. Conclusions

For the reasons set forth above, this Court should reverse the decision of the South Carolina Administrative Law Court and issue an order finding that the due process rights of Brook Waddle granted under the United States Constitution, the Constitution of South Carolina and the statutes discussed above have been violated. She requests an order reversing the decision of the lower court and requiring DHHS to pay for equipment necessary to care for her tracheotomy, including the oximeter cable ordered by her physician and other services in her approved plan of care. Brook requests a declaratory order requiring DHHS to include all contents described in 42 C.F.R. 431.201 in notices of adverse actions issued by DHHS or its agents and declaring that all notices issued by DHHS that do not contain all of the elements set forth in 42 C.F.R. 431.210 are null and void, requiring that the agency restore services and medical assistance in terminations or denials where defective or no notices have been provided, as required by 42 C.F.R. 431.231(c)(1).

Brook requests that this Court issue an order declaring that DHHS and its agents shall not dismiss any request for a fair hearing except where the appellant requests dismissal in writing or fails to appear at a scheduled hearing without good cause. Brook requests an order directing DHHS to address in a timely fashion (i.e. within 90 days of a request) all issues raised by appellants in requests for fair hearings where services are denied or not acted upon with reasonable promptness or where a hearing is requested because the appellant believes that the agency has taken an action erroneously. 42 C.F.R. 431.220(a)(2). She requests an order requiring DHHS to include in the Record on Appeal filed with the South Carolina Administrative Law

Court all records related to appellant's pending appeals in which a final administrative decision has not been issued, upon the request of the appellant.

Brook requests a declaratory order finding that the South Carolina Administrative Procedures Act, S.C. Code 1-23-380 requires judicial review upon exhaustion of administrative remedies and that a final Executive Branch decision must be issued within 90 days of DHHS receiving a request for a fair hearing, and that a remand by the South Carolina Administrative Law Court or DHHS "is not a substitute for a definitive and final administrative action." SMM § 2903.2(A). Brook requests an order declaring that S.C. Code 1-23-380 is not the sole remedy available to Medicaid participants and that the Administrative Procedures Act does not limit the scope of judicial review available under other means, including exercising her right to bring an action in federal court for violation of federal law.

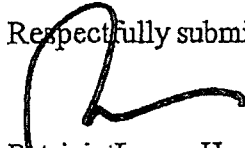
Brook requests that this Court declare that these Executive Branch agencies have violated the Separation of Powers Doctrine and requiring that a final administrative decision, appealable to the Judicial Branch, must be issued by the South Carolina Administrative Law Court within 90 days of a request for a fair hearing, except where the appellant requests an extension of time.

Brook requests an order directing DHHS to promulgate regulations for the administration of the Medicaid program, including Medicaid waiver programs administered by DDSN, and that the agency has acted without substantial justification in not previously promulgating regulations to carry out the program which do not conflict with federal law.

Finally, Brook requests that this Court declare that she is the prevailing party in this civil action and findings that the State has acted without substantial justification in this appeal, entitling her to legal fees. Brook requests directions on the correct procedure for filing a fee petition in this case.

Brook prays for such other relief as this Court shall determine to be necessary, just and proper.

Respectfully submitted,


Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
803 256 2017
plh.cola@att.net

Kenneth C. Anthony, Jr.
250 Magnolia Street
Spartanburg, South Carolina
864 582 2355

February 24, 2014

THE STATE OF SOUTH CAROLINA
IN THE STATE OF SOUTH CAROLINA

In the Court of Appeals

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

Case 2013-002415

Brook Waddle Appellant,

v

South Carolina Department of Health and Human Services Respondent.

DESIGNATION OF MATTER ON APPEAL

Appellant proposes the following to be included in the Record on Appeal:

1. All pleadings, , motions, orders and other documents filed in Waddle v. DHHS cases referred to in Brief
2. 21 Page Record on Appeal filed by DHHS with the Administrative Law Court
3. Unreported cases and public reports identified in Plaintiff's Brief
4. Accountability Reports of Administrative Law Court referenced in Brief

Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
803 256 2017
plh.cola@att.net

Kenneth C. Anthony, Jr.
250 Magnolia Street
Spartanburg, South Carolina
864 582 2355

Attorneys for Appellant

February 24, 2014

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION**

Peter B., Jimmy "Chip" E. and Michelle M.,

Plaintiffs,

V.

Marshall C. Sanford, Nikki Randhawa Haley, Anthony Keck, Beverly Buscemi, Kelly Floyd, Richard Huntress, the South Carolina Department of Health and Human Services and the South Carolina Department of Disabilities and Special Needs,

Defendants.

Civil Action Number:
6:10-767-TMC

JOINT INFORMAL STATUS REPORT

This joint status report is filed pursuant to this Court's order dated February 13, 2013, requesting "a joint informal status report about the outcome of the administrative hearing which was originally scheduled to begin November 13, 2012, in regard to Plaintiff Peter B." Docket No. 229.

This case was remanded by the South Carolina Court of Appeals on April 20, 2011 for a hearing on the merits in accordance with that Court's opinion and pursuant to 42 C.F.R. § 431.220(a)(1)-(2). According to the DHHS hearing officer, the case was received in the DHHS Office of Appeals and Hearings on December 16, 2011.

On September 24, 2012, DHHS hearing officer Janet Goode issued an order for a hearing to be held on November 13, 2012. The hearing was continued and has been rescheduled for March 12 and 13, 2013.

Respectfully submitted,

DAVIDSON & LINDEMANN, P.A.

BY: s/ Kenneth P. Woodington

WILLIAM H. DAVIDSON, II, Fed. I.D. No. 425

KENNETH P. WOODINGTON, Fed. I.D. No. 4741

DAVIDSON & LINDEMANN, P.A.

1611 DEVONSHIRE DRIVE, 2ND FLOOR

POST OFFICE BOX 8568

COLUMBIA, SOUTH CAROLINA 29202-8568

wdavidson@dml-law.com

kwoodington@dml-law.com

T: 803-806-8222

F: 803-806-8855

ATTORNEYS for Defendants

LAW OFFICES OF PATRICIA L. HARRISON

s/Patricia L. Harrison

PATRICIA L. HARRISON

FEDERAL I.D. NO: 6963

611 Holly Street

Columbia, South Carolina 29205

T: 803-256-2017;

Email: plh.cola@att.net

ATTORNEY FOR THE PLAINTIFFS

Columbia, South Carolina

February 20, 2013

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

Peter B., Jimmy "Chip" E.,
and Michelle M.,

Plaintiffs,

v.

Beverly Buscemi, Kelly Floyd,
the South Carolina Department
of Health and Human Services,
the South Carolina Department
of Disabilities and Special
Needs, Anthony Keck, and
Richard Huntress,

Defendants.

C/A No. 6:10-767-TMC

OPINION & ORDER

In their Amended Complaint, Plaintiffs seek declaratory and injunctive relief for alleged violations of Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132; Section 504 of the Rehabilitation Act of 1973 ("Section 504"); the Medicaid Act;¹ and 42 U.S.C. §§ 1983, 1985, and 1988. (Compl. ¶ 6). This matter is before the court on the Motion to Dismiss and/or Motion for Summary Judgment Based on Mootness and Motion for Summary Judgment filed by Defendants Beverly Buscemi, Kelly Floyd, Richard Huntress, Anthony Keck, South Carolina Department of Health and Human Services ("DHHS"), and the South Carolina Department of Disabilities and Special Needs ("DDSN") (Dkt. # 169 and 200); and Plaintiffs Peter B., Jimmy "Chip" E., and Michelle M.'s Amended Motion for Summary Judgment (Dkt. # 207). Responses and replies have been filed in regard to these motions. (Dkt. # 175, 181, 215, 214, and

¹Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v, is known as the Medicaid Act.

219). These motions are now ripe for ruling.²

I. Background/Procedural History

Medicaid is a cooperative federal-state program designed to furnish medical assistance to persons “whose income and resources are insufficient to meet the costs of necessary medical services.” 42 U.S.C. § 1396. The Centers for Medicare and Medicaid Services (“CMS”) administers the program on behalf of the Secretary of the United States Department of Health and Human Services. While states are not required to participate in Medicaid, all of them do. *Ark. Dep’t of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). Once a state chooses to participate in the Medicaid program, it must comply with the federal statutory and regulatory scheme. *Harris v. McRae*, 448 U.S. 297, 301 (1980). Each state’s Medicaid plan must specify a single state agency designated to administer the Medicaid plan. 42 C.F.R. § 431.10(a) and (e). In South Carolina, DHHS is the state agency designated to administer and supervise the Medicaid plan. S.C. Code Ann. § 44-6-30(1).

Plaintiffs in this action are three individuals who have varying degrees of mental and/or physical disabilities. Plaintiff Peter is 43 years old and has moderate mental retardation, hydrocephalus, diabetes, coronary heart disease, an anxiety disorder, and a history of stress-induced seizures. (Am. Compl. ¶ 34). Chip is 38 years old and has normal intelligence, severe cerebral palsy, and a speech disorder, and he is confined to a wheelchair. (Am. Compl. ¶¶ 85-86). Michelle is 37 years old and has profound mental retardation, autism, a seizure disorder, a sleep disorder, Parkinson’s disease, and Cattleman’s disease, and is unable to speak and recently has been confined to a

²The court decides these motions without a hearing as the parties’ arguments are fully set forth and supported in the memoranda and exhibits accompanying their motions. See LR 7.08 (stating “[h]earings on motions may be ordered by the Court in its discretion.”).

geri-chair or bed. (Am. Compl. ¶¶ 139-140; Pls.' Mem. Supp. Am. Mot. for Summ. J. at 3).

Plaintiffs participate in a Medicaid waiver program for persons with Mental Retardation/Related Disabilities ("MR/RD waiver"). (Am. Compl. ¶ 31).³ The MR/RD waiver program permits the federal government to waive the requirement that certain disabled persons must live in an institution in order to receive services funded by Medicaid. 42 U.S.C. § 1396n(c). DHHS contracts with DDSN to operate the MR/RD waiver program.

Plaintiffs allege Defendants have reduced or eliminated services (or threatened to do so) provided to them under the MR/RD waiver program and that this diminution in services will force them into institutions in violation of *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999). In *Olmstead*, the Supreme Court held that the "unjustified institutional isolation of persons with disabilities is a form of discrimination" prohibited by the ADA. *Id.* at 2187. The Supreme Court stated:

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 2190.

³As noted in the amicus memorandum, the terms "intellectual disability" and "person with intellectual disability" are being substituted in state law for "mental retardation" and "mentally retarded," respectively. (Dkt. # 174). Thus, the reference to this waiver as MR/RD is in the process of being replaced by Intellectual Disabilities and Related Disabilities waiver or ID/RD waiver. 2011 South Carolina Laws Act No. 47 (eff. June 7, 2011). However, 42 U.S.C. § 1396n(c) and various other federal laws and regulations still use the nomenclature "mental retardation." The court will continue to use the MR/RD terminology which was in effect at the time this case was filed and was used by the parties in their pleadings and memoranda.

Specifically, Plaintiffs Chip and Michelle challenge reductions which were to take place on January 1, 2010, as a result of a policy change which placed a 28-hour per week cap on personal care attendant ("PCA") services. (Am. Compl. ¶ 90). PCA services includes hands-on assistance with daily living. At that time, Chip was receiving 52 hours per week and Michelle was receiving 56 hours per week. (Am. Compl. ¶ 142; Defs.' Mem. Supp. Summ. J. Mot. at 3). Chip and Michelle pursued review of the proposed reductions in state proceedings and their PCA services hours were never reduced.

Plaintiff Peter's challenges differ. Peter participates in a DSSN residential program, Supervised Living Program II ("SLP II"). Peter has also been receiving MR/RD waiver services, including 12 hours of one-on-one companion services. (Am. Compl. 36, 48). In 2005, Peter was notified that his companion services were being terminated. (Am. Compl. ¶ 50). Peter appealed the final agency decision to DHHS and the hearing officer affirmed finding it lacked subject matter jurisdiction because Peter had failed to establish that the companion services were necessary to keep him out of an institution, and therefore such services were not services covered by the Medicaid waiver. Peter appealed to the Administrative Law Court ("ALC"), which also affirmed.

Peter subsequently appealed the ALC's decision and, on August 20, 2011, the South Carolina Court of Appeals reversed the ALC's conclusion that the hearing officer lacked subject matter jurisdiction and remanded the action to DHHS for a hearing. *Brown v. S.C. Dept. of Health & Human Servs.*, 709 S.E.2d 701 (S.C. Ct. App. 2011). Stating that subject matter jurisdiction is determined by the question to be answered and not by the answer, the court held that because Peter alleges his companion services are covered by Medicaid, DHHS had subject matter jurisdiction. *Brown*, 709 S.E.2d at 704. The court specifically stated it was not reaching the issue of whether

companion services qualify as a waiver. *Id.* at 705. Peter is currently awaiting a hearing before a DHHS officer.

Plaintiffs seek declaratory and injunctive relief finding Defendants have violated the ADA, Section 504, and the Medicaid Act, prohibiting the Defendants from reducing MR/RD Medicaid waiver services, and requiring Defendants to restore all services which were reduced or eliminated. (Am. Compl. ¶¶ 316-318). Further, Plaintiffs seek an order requiring “Defendants to provide all home and community based services which are determined by participants’ responsible treating physicians to be medically necessary, so long as the cost of these services is less than the cost of their care in a Regional Center, except where the orders of the treating physician involve Medicaid fraud or are outside of the reasonable standards of medical care, as determined by responsible and unbiased medical professionals.” (Am. Compl. ¶ 319). Finally, Plaintiffs seek an order declaring that Defendants Keck, Floyd, Huntress, and Buscemi denied Plaintiffs’ civil rights in violation of 42 U.S.C. §§ 1983 and 1988. (Am. Compl. ¶ 321).

II. Standard of Review

The court shall grant summary judgment “if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to a judgment as a matter of law.” Fed. R. Civ. P. 56(a). The movant bears the initial burden of demonstrating that summary judgment is appropriate; if the movant carries its burden, then the burden shifts to the non-movant to set forth specific facts showing that there is a genuine issue for trial. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). If a movant asserts that a fact cannot be disputed, it must support that assertion either by “citing to particular parts of materials in the record, including depositions, documents, electronically stored information, affidavits or declarations, stipulations (including those made for purposes of the motion only), admissions, interrogatory answers, or other

materials;" or "showing . . . that an adverse party cannot produce admissible evidence to support the fact." Fed.R.Civ.P. 56(c)(1).

Accordingly, to prevail on a motion for summary judgment, the movant must demonstrate that: (1) there is no genuine issue as to any material fact; and (2) that he is entitled to judgment as a matter of law. As to the first of these determinations, a fact is deemed "material" if proof of its existence or non-existence would affect disposition of the case under applicable law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). An issue of material fact is "genuine" if the evidence offered is such that a reasonable jury might return a verdict for the non-movant. *Id.* at 257. In determining whether a genuine issue has been raised, the court must construe all inferences and ambiguities against the movant and in favor of the non-moving party. *United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

Under this standard, the existence of a mere scintilla of evidence in support of the non-movant's position is insufficient to withstand the summary judgment motion. *Anderson*, 477 U.S. at 252. Likewise, conclusory allegations or denials, without more, are insufficient to preclude the granting of the summary judgment motion. *Ross v. Communications Satellite Corp.*, 759 F.2d 355, 365 (4th Cir. 1985). "Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment. Factual disputes that are irrelevant or unnecessary will not be counted." *Anderson*, 477 U.S. at 248.

III. Discussion

As set forth above, Plaintiffs contend Defendants have reduced certain in-home and community based personal health services and this reduction will force them into institutional settings, in violation of the holding in *Olmstead*. In their Amended Complaint, Plaintiffs allege four causes of action: 1) Violations of the ADA against

Defendants Keck, Buscemi, Floyd, Huntress, DHHS, and DDSN; 2) Violations of Section 504 against Defendants Keck, Buscemi, Floyd, Huntress, DHHS, and DDSN; 3) Violations of the Medicaid Act against all individual and agency Defendants; and 4) Violations of Sections 1983 and 1988 against individual Defendants Keck, Buscemni, Floyd, and Huntress. (Am. Compl. ¶¶ 248-302). As noted above, Plaintiffs have filed an amended summary judgment motion (Dkt. # 207), and Defendants have filed a summary judgment motion on the merits (Dkt. # 200) and a motion to dismiss and/or for summary judgment motion based on mootness (Dkt. #169). For the reasons set forth below, the court grants in part Defendants' motion and denies Plaintiffs' motion. Further, the court stays the remaining claims pending resolution of the state administrative proceedings.

Defendants contend that two of the Plaintiffs' claims are moot and all of Plaintiffs' claims are unripe or currently non-justiciable. (Defs.' Mem. Supp. Summ. J. Mot. at 13-24).⁴ Specifically, Defendants contend that two Plaintiffs, Chip and Michelle, have prevailed in a case before the South Carolina ALC, and DHHS has not appealed that decision, and further the threatened reductions never actually took place rendering these Plaintiffs' claims in the present action moot. Further, in regard to all Plaintiffs, Defendants contend that currently there is not a case or controversy and any potential future claims are not ripe. The court agrees that Chip and Michelle's claims are moot. However, the court finds the claims of Peter are not moot and ripe.

⁴As noted above, Defendants also filed an earlier motion to dismiss and/or for summary judgment based upon mootness. (Dkt. # 169). In this motion, Defendants seek the dismissal of the claims of Plaintiffs Chip and Michelle. The courts' decision to grant in part Defendants' later summary judgment motion provides the same relief, and therefore, moots Defendants' earlier motion to dismiss and/or for summary judgment. (Dkt. # 169). Furthermore, the court notes that Defendants specifically incorporated their prior filings into their subsequent summary judgment motion. (Dkt. # 200 Defs.' Mem. Supp. Summ. J. Mot. at 12).

Turning to the Amended Complaint, the court notes that Plaintiffs seek the following relief:

1) "that this Court assume jurisdiction over this action and maintain continuing jurisdiction until defendants are in full compliance with every order of this Court." (Am. Compl. ¶ 315).

2) "an order finding that Defendants included in Counts One and Two have violated the ADA and Section 504 of the Rehabilitation Act as set forth in this Complaint." (Am. Compl. ¶ 316).

3) "an order finding that the Defendants included in Count Three have violated the Medicaid Act." (Am. Compl. ¶ 317).

4) "an order prohibiting the Defendants from reducing MR/RD Medicaid waiver services and requiring Defendants to restore all services which were reduced or eliminated by amendments to the State's Medicaid applications to CMS." (Am. Compl. ¶ 318).

5) "an order directing Defendants to provide all home and community based services which are determined by participants' responsible treating physicians to be medically necessary, so long as the cost of these services is less than the cost of their care in a Regional Center, except where the orders of the treating physician involve Medicaid fraud or are outside of the reasonable standards of medical care, as determined by responsible and unbiased medical professionals." (Am. Compl. ¶ 319).

6) "other relief as shall be determined by this Court to be just and equitable, including payment of legal fees and costs of this action." (Am. Compl. ¶ 320).

7) "[d]eclare that individual Defendants Sanford, Haley, Keck, Floyd, Huntress and Buscemi have acted to deny the civil rights of the Plaintiffs in violation of 42 U.S.C.

§§ 1983 and 1988.” (Am. Compl. ¶ 321).⁵

Plaintiffs have attempted to broaden the scope of their Amended Complaint by asserting several new issues and arguments which are not properly before this court as these claims were not raised in the Amended Complaint. For example, in their amended summary judgment motion, Plaintiffs now request an “order requiring DHHS to issue a final determination on all fair hearing appeals brought by MR/RD waiver program participants within 90 days of the request and requiring the hearing officers to base their decisions exclusively on evidence introduced at the hearing [and] an order prohibiting DHHS officials and hearing officers from participating in ex parte communications with employees of DDSN or other third parties on matters involving pending cases” (Dkt. # 207 - Pls.’ Mem. Supp. Am. Summ. J. Mot. at 18)(internal citation and quotation marks omitted). The court has carefully reviewed the Amended Complaint and limits its discussion to those issues and claims raised therein.

First, the court finds it unnecessary to enter a separate order directing Defendants to comply with the court’s orders or to establish its continuing jurisdiction in regard to compliance with its orders. At this time, there are no credible allegations that Defendants currently are not in compliance with the court’s prior orders. Furthermore, if Plaintiffs believe Defendants are violating a court order, they can file an appropriate motion in that regard.

Plaintiffs’ request for a declaration that Defendants’ past conduct violated Section 504, the Medicaid Act, or their due process rights seeks the kind of retrospective relief that the Supreme Court has found to be barred by the Eleventh Amendment. See *Green v. Mansour*, 474 U.S. 64, 68-73 (1986) (holding that petitioners could not obtain

⁵Defendants Mark Sanford and Nikki Haley were dismissed from this action on June 13, 2012. (Dkt. # 185).

declaratory judgment that a state's former method of calculating welfare benefits violated federal law where there was no ongoing violation). Nor is this request for relief covered by the exception recognized by the Supreme Court in *Ex Parte Young*, 209 U.S. 123 (1908) and its progeny. Where there is an ongoing violation, however, such a claim remains a viable claim, as discussed below.

As noted above, Plaintiffs also request an order

directing Defendants to provide all home and community based services which are determined by participants' responsible treating physicians to be medically necessary, so long as the cost of these services is less than the cost of their care in a Regional Center, except where the orders of the treating physician involve Medicaid fraud or are outside of the reasonable standards of medical care, as determined by responsible and unbiased medical professionals.

(Am. Compl. ¶ 319).⁶ This request for relief appears to apply to only Peter's claims as he contends that his companion services are medically necessary. (See Pls.' Mem.

⁶It now appears Plaintiffs are seeking different relief in this regard. In their memorandum supporting their Amended Motion for Summary Judgment, Plaintiffs state they are now seeking the following remedial relief:

Plaintiffs request that this Court rule that until State agencies promulgate regulations in compliance with the Medicaid Act and the South Carolina Medical Practice Act that DDSN and DHHS must apply Social Security regulations related to the weight given to the opinions of the treating physicians in determining the need for Medicaid services.

(Pls.' Mem. Supp. Am. Mot. for Summ. J. Mot. at 26). Citing *Doe II*, 419 Fed. Appx. 411, Plaintiffs contends the court may do so under its broad equitable powers to style any appropriate remedial relief. First, Plaintiffs did not seek this relief in their Amended Complaint and first raised this request for relief in their summary judgment motion. Moreover, the cases cited by Plaintiffs are distinguishable. *Alexander v. Hil*, 707 F.2d 780, 783 (4th Cir. 1983), was a class action involving noncompliance with the court's prior orders, and *Smith v. Miller*, 665 F.2d 172 (7th Cir. 1981), was also a class action where the court held that the district court did not abuse its discretion by ordering that all requests for Medicaid benefits not timely processed under prior approval procedures were deemed automatically approved. In these cases, the courts were enforcing compliance with prior court orders and the Medicaid Act. Here, Plaintiffs have not established that the state is acting in derogation of any prior orders or the Medicaid Act in its treatment of treating physicians' opinions.

Supp. Am. Summ. J. Mot. at 27).

Finally, Plaintiffs are seeking an order requiring the restoration of all of their MR/RD waiver services which have been reduced or eliminated and prohibiting Defendants from reducing their MR/RD waiver services "by amendments to the State's Medicaid applications to CMS." (Am. Compl. ¶ 318). As discussed below, this request appears to apply only to Chip and Michelle, and their MR/RD waiver services were never actually reduced based upon the 2010 caps.⁷ Plaintiffs Chip and Michelle filed an appeal of DHHS's administrative decision to reduce or discontinue certain MR/RD waiver services with the ALC.⁸ On November 9, 2011, the ALC filed an order reversing the DHHS's decisions to reduce and or terminate services or supplies to these Plaintiffs. (Dkt. # 169 Defs.' Mem. Supp. Summ. J. Mot. Ex. 2 - ALC's Order of Nov. 9, 2011). The ALC held that the actions taken by the DHHS to reduce or cap Plaintiff's services did not have the force and effect of law because the caps were not promulgated as a regulation. *Id.* at 14. Further, the ALC ordered that the DHHS must provide each Plaintiff with an evidentiary hearing before taking any further action regarding Plaintiffs'

⁷Plaintiffs cite to the Report and Recommendation filed in this action on November 24, 2010, in regard to the temporary injunction (Dkt. # 71) as evidence that Chip and Michelle's service were reduced. (Dkt. # 175 - Pls.' Mem. Opp. Summ. Defs.' Summ. J. Mot. at 6). In her report, the Magistrate Judge stated that "there has been a diminution in service hours for both Chip and Michelle, which . . . their treating physicians find significant." *Id.* However, it appears that this particular sentence is a misstatement of the facts and Plaintiffs have not presented any evidence which establishes that the services for these Plaintiffs were ever reduced. More accurately, there was a threatened diminution in the services; however, the services were never actually reduced. Furthermore, the Magistrate Judge clearly recognized in her Report that the services provided to Michelle and Chip had never actually been reduced. (See e.g. Report at 23)(stating that "[w]ith 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 instance of Michelle M. and Chip W., they maintain even now.")

⁸The ALC consolidated four individual appeals because they concerned the same question of law. (Dkt. # 169-2 - ALC's Order of Nov. 9, 2011, at 2 n.1).

benefits under the MR/RD waiver. *Id.* at 16. DHHS did not appeal this order. There is no ongoing violation of the Medicaid Act, Section 504, or the ADA, in regard to the Plaintiffs Chip and Michelle, and they are receiving the relief requested. Accordingly, it appears their claims are moot.

In response, Plaintiffs argue that they are seeking systemic changes to force the DHHS into compliance with the ADA, Section 504, the Medicaid Act, and the holding in *Olmstead*. (Dkt. # 175 - Pls.' Mem. Opp. Defs.' Summ. J. Mot. at 2). Plaintiffs specifically state that the claims raised in their Amended Complaint are not limited to the January 1, 2010 reductions, but rather allege ongoing and systemic violations. Further, Plaintiffs note that they are requesting an award of attorney's fees and costs pursuant to 42 U.S.C. § 1988, particularly in light of Defendants' claim that Plaintiffs have prevailed in this case. (Dkt. # 175 - Pls.' Mem. Opp. Defs.' Summ. J. Mot. at 10). Finally, Plaintiffs argue that their claims are not moot because Defendants' conduct can reasonably be expected to recur. *Id.* at 12.⁹ Plaintiffs contend that "[c]ontinuing to apply illegal caps on every waiver participant who does not have a case pending in the federal court is not an appropriate remedy." (Dkt. # 220 - Pls.' Mem. Opp. Summ. J. Mot. at 8).

While federal courts may provide prospective injunctive relief where a state is engaged in an ongoing violation of federal law, *see Edelman v. Jordan*, 415 U.S. 651, 664, 674 (1974), a federal court acting pursuant to the Declaratory Judgment Act may declare the rights of a party only where there exists an "actual controversy." *Steffel v.*

⁹Furthermore, Plaintiffs contend that Defendants continue to enforce a cap of 240 hours per month on respite hours. (Dkt. # 215 - Pls.' Mem. Opp. Defs.' Summ. J. Mot. at 2). Plaintiffs cite to Chip's affidavit in which he avers: "My service coordinator tells me that no one can go over 240 hours a month of respite care." (Dkt. # 207-27 ¶3). These general allegations and the evidence cited by Plaintiffs as support are insufficient to create a genuine issue of material fact regarding whether Plaintiffs Chip and Michelle's services have been reduced.

Thompson, 415 U.S. 452, 462 (1974).¹⁰

Actions for declaratory or injunctive relief must present a live controversy justiciable under Article III of the Constitution. See *MedImmune, Inc. v. Genentech, Inc.*, ___ U.S. ___, 127 S.Ct. 764, 771, 166 L.Ed.2d 604 (2007) (declaratory judgment); *City of Los Angeles v. Lyons*, 461 U.S. 95, 102 (1983) (injunctive relief). An actual, justiciable controversy must exist not only when the suit is initiated, but also at the time that the party's entitlement to the requested relief is decided. See *Golden v. Zwickler*, 394 U.S. 103, 108 (1969). It is further settled in this regard that a past injury, without more, cannot form the basis for either injunctive or declaratory relief. See *O'Shea v. Littleton*, 414 U.S. 488, 495-96 (1974) ("Past exposure to illegal conduct does not in itself show a present case or controversy regarding injunctive relief . . . if unaccompanied by any continuing, present adverse effects."); see also *Green v. Mansour*, 474 U.S. at 74 (rejecting the view that "declaratory judgments expressly adjudicating the question of past violations are routinely available").

To determine whether an "actual controversy" exists, the court must determine "whether the facts alleged, under all the circumstances, show that there is a substantial controversy, between parties having adverse legal interests, of sufficient immediacy . . . to warrant the issuance of a declaratory judgment." *Golden*, 394 U.S. at 108 (quoting *Maryland Casualty Co. v. Pacific Coal & Oil Co.*, 312 U.S. 270, 273 (1941)). A party seeking declaratory relief from a prospective violation of the party's rights must show that the grievance is real and immediate, rather than merely conjectural. See *Golden*,

¹⁰The Declaratory Judgment Act provides, in part, that "[i]n a case of actual controversy within its jurisdiction, . . . any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. § 2201.

394 U.S. at 109.

A claim is moot “when the issues presented are no longer ‘live’ or the parties lack a legally cognizable interest in the outcome.” *Powell v. McCormack*, 395 U.S. 486, 496 (1969). “The requisite personal interest that must exist at the commencement of the litigation . . . must continue throughout its existence” *U.S. Parole Comm’n v. Geraghty*, 445 U.S. 388, 397(1980) (quotation omitted). Otherwise, a court’s ruling would be an advisory opinion on hypothetical facts. *White v. Nat’l Union Fire Ins. Co.*, 913 F.2d 165, 167 (4th Cir. 1990) (internal quotation omitted).

A claim that is moot may be considered by the Court, however, if it is “capable of repetition, yet evading review.” *Fed. Election Comm’n v. Wis. Right to Life, Inc.*, 551 U.S. 449, 462 (2007). This exception is limited to exceptional situations. See *Incumaa v. Ozmint*, 507 F.3d 281, 289 (1983). “In the absence of a class action, the ‘capable of repetition, yet evading review’ doctrine [is] limited to the situation where two elements combined: (1) the challenged action was in its duration too short to be fully litigated prior to its cessation or expiration, and (2) there was a reasonable expectation that the same complaining party would be subjected to the same action again.” *Weinstein v. Bradford*, 423 U.S. 147, 149 (1975).

First, as this is not a class action, it is insufficient as a matter of law for Plaintiffs to argue that the challenged conduct may recur as to others; it must be as to the same complaining party. See *Spencer v. Kemna*, 523 U.S. 1, 17 (1998). Second, simply because it is possible for DHHS to resume its challenged conduct does not create a reasonable expectation that it will. See *Am. Legion Post 7 v. City of Durham*, 239 F.3d 601, 605–06 (4th Cir. 2001) (finding moot a challenge to a repealed ordinance when, even though the government was “free to re-enact th[e] ordinance,” there was no indication that it would). In fact, courts often give considerable credence to a

government's indication that it will not repeat the challenged conduct. See, e.g., *Chi. United Indus., Ltd. v. City of Chi.*, 445 F.3d 940, 947 (7th Cir. 2006) (holding "when the defendant is not a private citizen but a government actor, there is a rebuttable presumption that the objectionable behavior will not recur" (quoting *Troiano v. Supervisor of Elections in Palm Beach Cnty.*, 382 F.3d 1276, 1283 (11th Cir. 2004))). See also *Nat'l Adver. Co. v. City of Miami*, 402 F.3d 1329, 1333 (11th Cir. 2005) (per curiam) ("[G]overnmental entities and officials have been given considerably more leeway than private parties in the presumption that they are unlikely to resume illegal activities." (quotation omitted)).

There is no indication that in the future Defendants will apply the 2010 caps to Plaintiffs Michelle and Chip, especially in light of the ALC's decision.¹¹ In fact, Plaintiffs themselves have stated that "DHHS is now prohibited by these orders from enforcing the January 1, 2010 caps on services of these two plaintiffs based on the decision of the Administrative Law Court." (Dkt. # 166 at 41).

Furthermore, Plaintiffs cannot demonstrate that Defendants' alleged wrongful

¹¹The court also believes the instant action is distinguishable from the recent Fourth Circuit Court of Appeals' decision in *Pashby v. Delia*, 2013 WL 791829 (4th Cir. filed March 5, 2013). In *Pashby*, a class action suit, Medicaid recipients contended that a specific new policy contravened the ADA, Section 504 of the Rehabilitation Act, and the Social Security Act by imposing stricter eligibility requirements for in-home services. They further alleged that they were not provided sufficient notice of the termination of their services in violation of their due process rights. The Fourth Circuit held that the class action claims were not moot based upon the voluntary dismissal of administrative appeals by the named plaintiffs and reinstatement of the services by the defendants because the behavior is likely to recur. *Id.* at *4. The court found that the defendants could reassess the recipients' needs at any time and cancel their services under the challenged policy. First, this is not a class action and, furthermore, Defendants are bound by the ALC's decision which reversed the decision to reduce and/or terminate Chip and Michelle's services. Dkt. # 207-30 at 16). Further, the ALC concluded that because the 2010 policy regarding caps was not promulgated as a regulation under state law, Plaintiffs were entitled to a hearing before their services could be reduced. *Id.* at 14.

conduct is capable of repetition, yet evading review simply by broadening the nature of the allegedly wrongful which is challenged. *Larsen v. United States Navy*, 2012 WL 3672985 (D.D.C. 2012)(holding wrong at issue for mootness purposes is limited to plaintiffs' theory alleged in complaint). See also *Clarke v. United States*, 915 F.2d 699, 703 (D.D.C. 1990)("where plaintiffs are resisting a mootness claim . . . they must be estopped to assert a broader notion of their injury than the one on which they originally sought relief.")¹²

Here, Plaintiffs Chip and Michelle in their Amended Complaint challenge the reductions which occurred based upon the 2010 caps. However, now Plaintiffs, in the absence of proper pleadings, seek to permanently prohibit *any* reduction in Plaintiffs' waiver services. (See e.g., Dkt. # 175 - Pls.' Mem Opp. Summ. J. Mot. at 7). Based on the claims before the court, the court cannot prohibit DHHS from reducing these Plaintiffs' or other individual's MR/RD waiver services in the future. However, DHHS must provide the appropriate due process if any services are cut or terminated in the future. Furthermore, at this time, any presumption of future violations as to Chip and Michelle would be purely speculative making any opinion the court might render an advisory opinion.

Finally, Plaintiffs contend that the opinion in *Doe v. Kidd*, 501 S.E.2d 348, 355 (4th Cir. 2007) ("*Doe I*"), precludes finding Chip and Michelle's claims are moot. The court disagrees. In *Doe*, Doe challenged Appellee's failure to provide her with residential rehabilitation services promptly. Despite Appellees providing Doe with some services,

¹²Plaintiffs also contend that their request for attorney's fees pursuant to 42 U.S.C. §1988 renders their claims "live" especially in light of Defendants' admission that they are the prevailing party. (Dkt. # 175 - Pls.' Mem. Opp. Defs.' Summ. J. Mot. at 10). As the court finds at this time Peter's claims are not moot, the court need not address this issue.

the Fourth Circuit found this claim was not moot as there was an ongoing violation based upon Appellee's admission that Doe was placed in a CTHH for respite services or until her true status is determined. *Doe*, 501 S.E.2d at 354. The court specifically held that the appellees had not voluntarily ceased the wrongful conduct. *Id.*¹³ Here, however, Chip and Michelle's services have not been reduced and the claims they raised in regard to the threatened reductions which were based upon the 2010 caps are no longer live.

Furthermore, Plaintiffs' argument that the challenges they are raising are systemic problems and being applied to other waiver participants, (Dkt. # 175 - Pls.' Mem. Opp. Summ. J. Mot. 8; Dkt. # 220 - Pls.' Mem. Opp. Summ. J. Mot. at 5, 8), does not render Chip and Michelle's claims live. While a class action may remain live despite the mootness of the claims of the class representative, see e.g. *Sosna v. Iowa*, 419 U.S. 393, 401 (1975)(holding when a class representative's claim is mooted after class certification, the Supreme Court has held that federal courts retain jurisdiction over the class action), this action is not a class action. In their Amended Complaint, Plaintiffs challenge only specific actions which were applied to them. While others may be subject to the same actions of Defendants, Plaintiffs may raise only their own claims. Absent a special relationship or class action, the Plaintiffs at the present time do not have standing to assert the rights of these third parties. See *Warth v. Seldin*, 422 U.S. 490, 499 (1975)("[T]he plaintiff generally must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties.").

Based on the foregoing, the court finds the claims of Chip and Michelle are moot.

¹³Contrary to Plaintiffs' assertions, the court did not hold that the claim was not moot because it could reasonably be expected to recur. (See Dkt. # 175 - Pls.' Mem. Opp. Defs.' Summ. Jud. Mot. at 12).

There is no genuine issue of material fact - the waiver services of Chip and Michelle have not been reduced. Moreover, any presumption of future violations in this case would be purely speculative at this time, making any opinion the court might render an advisory opinion.

While Peter's services have also not been reduced at this time, the claims raised by Peter remain live. The parties dispute whether Peter has requested a hearing, but it is undisputed that Peter has yet to have such a hearing on his claims. In an informal status report requested by the court, the parties represented that a hearing is currently scheduled in Peter's administrative action for March 12-13, 2013. (Dkt. # 230 at 1). However, in another action currently pending before the court, *Kobe v. Keck, et.al.*, Plaintiffs subsequently filed a letter dated February 26, 2013, addressed to the DHHS hearing officer in which DHHS stated that it had decided not to contest Peter's appeal and that a hearing was unnecessary. *Kobe v. Keck, et.al.*, C/A No.3:11-cv-1146-TMC Dkt. # 204 Ex. 10). At this time, it appears that Peter's claims are not moot.

However, the court finds some of Peter's claims are not yet ripe. The ripeness doctrine "prevent[s] the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements over administrative policies." *Abbott Labs. v. Gardner*, 387 U.S. 136, 148 (1967), *abrogated on other grounds by Califano v. Sanders*, 430 U.S. 99 (1977). The Supreme Court has enunciated two factors relevant to a ripeness decision: first, the fitness of the issues for judicial resolution, and second, the hardship to the parties of withholding court consideration. *Id.* at 149. "For a claim to be ripe, it must involve an administrative decision [that] has been formalized and its effects felt in a concrete way by the challenging parties." *Pashby*, 2013 WL 791829 * 5 (internal citations and quotation marks omitted). "A claim is not ripe for adjudication if it rests upon 'contingent future events that may not occur as anticipated, or indeed may

not occur at all.” *McGhee v. Director, Dept. of Mental Health & Hygiene*, 153 F.3d 721 (4th Cir. 1998) (unpublished)(internal quotation and citations omitted). Peter's appeal to the ALC is apparently still pending and the possibility remains that he will receive the relief he seeks. Thus, the injury of which he complains remains contingent upon future events.

“Federal ripeness doctrine . . . counsels against adjudication of questions that might be altered or dissolved by further action in the state court.” *Id.* In *McGhee*, the Fourth Circuit remanded the action with instructions for the district court to stay the action pending resolution of the state proceedings. *Id.* The court noted that “[s]taying any decision pending final state court action is consistent with the dual federal-state nature of the Medicaid system and helps preserve the states' important role in administering the program.” *Id.* The court finds a stay appropriate in this case as well. Accordingly, the court stays this action pending the resolution of the state proceedings.

Conclusion

Based on the foregoing, Defendants' Summary Judgment Motion (Dkt. # 200) is **GRANTED in part and DENIED in part**; Defendants' Motion to Dismiss and/or for Summary Judgment Motion (Dkt. # 169) is **DENIED as moot**; and Plaintiffs' Amended Summary Judgment Motion is **DENIED** (Dkt. # 207). Plaintiffs Chip E. and Michelle M. are dismissed. Further, this action is stayed pending the resolution of the state proceedings.

IT IS SO ORDERED.

s/Timothy M. Cain
United States District Judge

Anderson, South Carolina
March 7, 2013

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM THE SOUTH CAROLINA ADMINISTRATIVE LAW COURT

Honorable Carolyn Matthews

Docket No.: 13-ALJ-08-0159-AP

Peter Brown,
Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent.

AFFIDAVIT OF PATRICIA LOGAN HARRISON

Patricia Logan Harrison, file under penalties of perjury this Affidavit in support of a petition for fees in this case based on personal knowledge of the facts set forth herein.

1. The South Carolina Department of Health and Human Services and/or its agent, the South Carolina Department of Disabilities and Special Needs have been defendants in every appellate case I have won in the Fourth Circuit, the South Carolina Supreme Court and the South Carolina Court of Appeals.

2. In 2004, the South Carolina Supreme Court upheld the ruling of the circuit court judge in *Ex Parte: SCDHHS v. Jackson*, 364 S.C. 527 (2005), preventing DHHS from taking a large part of the settlement of a lawsuit in behalf of the two severely disabled children I represented.

3. That case was decided in 2004 and reaffirmed in my client's favor by the Supreme Court after the State's motion for rehearing was granted.
4. Three times, my cases filed against the defendant(s) in this case have been certified to the South Carolina Supreme Court pursuant to SCRCP 204, which provides for that court to hear cases of extreme public importance and we have prevailed in each of those cases.
5. Prior to, and since this lawsuit was filed, I have litigated cases in the probate court, including hotly contested will contests, guardianships and cases involving large trusts.
6. In one guardianship case, I was awarded a fee by the circuit court of \$105,000 in a contested guardianship matter (the amount I requested).
7. Much of my legal work is for poor and/or disabled persons, like the Appellant in this case, where I charge either a reduced fee or no fee, or take the case on a contingency basis.
8. I have an AV rating with Martindal Hubbel and I have been named as a "Superlawyer" for several years.
9. I have been practicing law for approximately twenty-five years and my resume is attached.
10. The attached affidavit of Lynn S. Carman describes the complexity and difficulties inherent in litigating Medicaid cases. Exhibit 1.
11. This case has been one of the most difficult cases of my career, in part due to retaliation by DHHS and its agents.
12. I am currently charging and receiving rates of up to \$395.00 an hour in noncontested matters in the probate court, where the demands of the court and the parties are significantly less than in this case and the payment of fees is not contingent.

13. In those fee-paying cases, my fees are normally paid promptly by the client without haggling about rates or performance.

14. I frequently turn away paying clients due to the demands on my time in Medicaid appeals.

15. This case and others are referred to me by probate court attorneys who do not have litigation experience outside of the probate court and are not willing to take on a case that requires hundreds of hours of work.

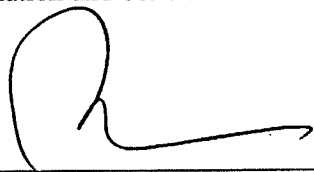
16. I frequently try to encourage other attorneys to take on cases involving Medicaid appeals, but my experience is that private attorneys will only take on cases where they are getting paid and they will not even consider these cases that go on for years and years.

17. I have spent in excess of 700 hours in the state appeals in this case.

18. Peter or his family have paid in excess of \$60,000 for legal services during the course of these proceedings.

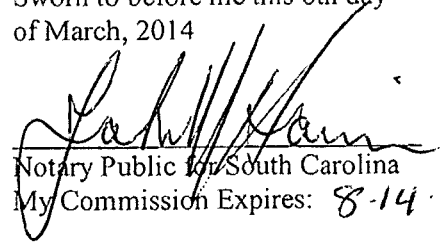
19. I request permission to provide affidavits in support of an hourly rate of \$450.00 per hour in this case.

I declare that the foregoing is true, under penalty of perjury, to the best of my knowledge, information and belief. Executed in Columbia, South Carolina on this 6th day of March, 2014.



Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
plh.cola@att.net
pharrison@loganharrisonlaw.com
803 256 2017

Sworn to before me this 6th day
of March, 2014


Notary Public for South Carolina

My Commission Expires: 8-14-2017

STATE OF CALIFORNIA

DECLARATION OF LYNN S. CARMAN

COUNTY OF MARIN

Now comes Lynn S. Carman, who swears and affirms:

1. I have been a member of the State Bar in the State of California for 54 years and I am admitted to practice in all state and federal courts in California, the Ninth Circuit Court of Appeals and the United States Supreme Court.
2. I graduated from Stanford in 1950 and from Golden Gate University School of Law in 1959..
3. I formerly served as the Deputy District Attorney for El Dorado County, as the Public Defender in El Dorado County and as the President of the El Dorado County Bar Association.
4. I have more than 31 years of experience litigating Medicaid cases in the state and federal courts.
5. In 2004, I founded the Medicaid Defense Fund, as an organization to assure that the State Medicaid programs follow federal law, in particular that the reimbursements to providers are sufficient to ensure that quality care is furnished.
6. For many years, I have successfully litigated Medicaid budget cuts to providers which violate the Medicaid Act, on the basis that rates which have been set for purely budgetary reasons preclude quality care being furnished.
7. Some of the non-Medicaid cases I have litigated include:

Mallick v. Superior Court, 89 Cal.App.3d 434 (1979): In this case, the Golden Gate

Bridge District was ordered to set aside the bridge toll increase of 25 cents from \$1 to \$1.25. This case settled, by reducing the toll to collect back the overcharge and an agreement to spend \$2.2 million to purchase the Bay Area's first fleet of handicapped-equipped buses. I was awarded \$40,000 attorneys' fees.

McGhee v. Bank of America, 60 Cal.App.3d 442 (1976), (tried as Wilson v. Bank of America, (unreported)). I was lead counsel in obtaining \$101 million judgement against Bank of America in 7-day court trial. This case settled for agreement to cease requiring impounds to be paid to the bank, and payment of approximately \$35 million to the victim borrowers. I was awarded \$1.4 million attorneys' fees. This and others in which I was lead counsel, established class action and trust law precedents for class actions against banks in California, (such as Wilson v. San Francisco Federal S&L Assn., 62 Cal.App.3d 1 (1976); Bodle v. Well Fargo (unreported)); in each of which attorneys' fees were awarded.

8. Some of the Medicaid cases I have litigated include:

Cowan v. Myers, 187 Cal.App.3d 968 (1986): In this case, the Superior Court ruled that limiting Medicaid coverage only to care, which is medically necessary to prevent death or significant disability, violated the federal Medicaid Act. The legislature then amended the state Medicaid Act to increase Medicaid coverage as a result of this case.

10% Medicaid fee cut case: In 1987 the State Department of Health Services cut payments to all Medicaid providers by 10%. In this litigation, the U.S. District Court in Sacramento permanently enjoined the cut. I was awarded \$90,000 attorneys fees.

Medicaid budget case: In 1990 I obtained an injunction in U.S. District Court in Sacramento requiring the State of California to pay all Medicaid providers whether there was a budget or no budget. As result of this case the legislature enacted a provision for a continuing appropriation to pay all Medicaid providers during these annual budget impasses.

5% Medicaid fee cut case: Clayworth v. Bonta, 295 F.Supp.2d 1100 (E.D.Cal.2003). In 2003 the legislature enacted a 5% cut in Medicaid reimbursement for all fee-for-services doctors and pharmacies. I obtained injunction to enjoin the 5% rate cut. (*Reversed, other grounds*).

10% Medicaid payment cuts of 2008: Independent Living Center ("ILC") v. Shewry, 543 F.3d 1047 (9th Cir. 2008); ILC v. Maxwell-Jolly, 572 F.3d 644 (9th Cir. 2009): In 2008 the legislature enacted a 10% across-the-board cut in Medicaid reimbursement for fee-for-service providers. I obtained two injunctions to stop the cut for doctors, pharmacies, dentists, adult care health centers, optometrists, home health providers, and non-emergency transporters. (Not overruled, though vacated, other grounds, Douglas v. Independent Living Center, 565 U.S. ___, 132 S.Ct. 1204 (2012); currently, in court-ordered mediation).

10% Medicaid payment cut of 2009: In 2009 the legislature enacted a 5% rate cut to Medicaid pharmacies. Through the Medicaid Defense Fund, I obtained an injunction to

stop the cut. Affirmed, (Managed Pharmacy Care v. Maxwell-Jolly, unreported, 9th Cir. 2010; not overruled, though vacated, other grounds, Douglas, *supra*; currently, in court-ordered mediation).

10% Medicaid payment cut to pharmacies: The state legislature enacted a 10% reimbursement cut to providers to commence on June 1, 2011. As lead attorney for the Medicaid Defense Fund, I obtained injunction to stop this cut in the district court. This decision was reversed May 24, 2013, (Managed Pharmacy Care v. Douglas, __ F.3d __ 9th Cir. 2013; *certiorari petition pending*, No. 13-253).

9. The issue in the 2008-2009 cases was whether a person threatened with injury from continuous State action contrary to federal law, has standing to sue for injunctive relief under the Supremacy Clause. The new issue in the 2011 Medicaid rate cut, is whether courts must defer to decisions of the Secretary of the U.S. Dept. of Health and Human Services, without any findings but only conclusions that Medicaid provider payment cuts comply with the quality of care provision of the Medicaid rate statute, 42 U.S.C. § 1396a(a)(30)(A). This provision requires states to assure that its payments to Medicaid providers are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available to the general population in the geographic area.
10. Currently, the implementation of the 10% Medicaid pharmacy payment cuts, in the Managed Pharmacy Care case, has been temporarily postponed to January, 2014, because

even the Director of the state Department of Health Care Services has determined that the 10% cuts, if not delayed or rescinded, for some or all pharmaceuticals, will injure access of pharmacies to pharmacy services; and, the Director is possibly awaiting determination by the Supreme Court whether it will issue, or not issue, *certiorari* at the conference presently scheduled for January 10, 2014.

11. I became acquainted with Patricia Logan Harrison as a result of her work in the *Doe v. Kidd* cases when I was preparing briefs to file in the United States Supreme Court in the 2008-2009 rate reduction cases.
12. Ms. Harrison is well respected nationally as a result of her work in Medicaid litigation cases and she has been of tremendous assistance to me in editing briefs, discussions of litigation strategy and in sharing information on Medicaid cases from other parts of the country.
13. Medicaid litigation is the most complex of the litigation I have done during my 54 year career as a lawyer and there are extremely few lawyers in the country, like Ms. Harrison, who are intellectually capable of taking on these cases and willing and courageous enough to persist through years of appeals.
14. The *Doe v. Kidd* case was a landmark case in the field of Medicaid law, because it established the right to bring a private action to enforce the Medicaid Act in the Fourth Circuit. It is especially important, considering that circuits such as the Ninth Circuit have, now, indicated they may not continue to enforce the quality of care and equal access provisions of the Medicaid Act. Her achievement bodes that recipients may nevertheless continue to obtain adequate access to Medicaid services, by appropriate judicial

enforcement of the “prompt services” requirement of 42 U.S.C. § 1396a(a)(8).

15. *Doe v. Kidd* has been cited in briefs filed by the United States Department of Justice, by attorneys around the country and by other courts.
16. I have reviewed the docket sheet, the motion for fees (Entry 236), the summary of legal fees by category (Entry 245-5) and the timesheets of Patricia Logan Harrison (Entry 236-1) and I find them to be most reasonable and necessary to encourage the enforcement of the Medicaid Act. First: I have reviewed Ms. Harrison's total time requested and the breakdown of the time between the different phases and tasks in the case. I found the time she spent overall and in each category to be most reasonable and necessary, given the complicated nature of Medicaid appeals which were compounded by the defenses put up by the state agency. Second, the time Ms. Harrison has spent is not out of line compared with the time I spend in complicated Medicaid litigation. Third, specifically, as to the 489 hours spent on the first appeal to the Fourth Circuit, this amount of time is not out line with the appeals I have done and I, myself, have spent upwards to 500 hours in a single appeal to the Court of Appeals. Fourth, unless appropriate fees, with multipliers for the risk and length of these monstrous cases, particularly this one, are awarded by the courts pursuant to the intent of Congress in 42 U.S.C. § 1982/1988, the Act will simply not be enforced because attorneys will not take these cases, with their complexity and absorption of their capacities, unless they are paid appropriately.
17. It appears that Ms. Harrison spent slightly less than 500 hours preparing briefs and the joint appendix on the first appeal to the Fourth Circuit. First of all, this is one of the most

complicated Medicaid cases I have ever seen, on so many different levels of complexities. In my experience litigating complex class actions and complex Medicaid cases, this is a conservative amount of time for an appeal from a district court in a case like this, and I would have expected briefing and preparation of arguments in the Court of Appeals of such a complicated issue to require more time.

18. At the time this case was on appeal, there was a fear, and still is a fear of, a national trend toward restricting access to the federal courts in Medicaid cases after *Gonzaga*, but this trend has since been reversed, in part as a result of exceptional cases like *Doe v. Kidd*, where attorneys were willing and courageous enough to undertake litigation at great expense with no certainty of being paid for their work.
19. The fact that there was not a team of lawyers doing this briefing for the plaintiff is remarkable, especially considering the resources available to the State and the nearly insurmountable obstacle Doe faced in both the district court and the Court of Appeals of overcoming the presumption that the State acted lawfully.
20. Spending just 120 hours in preparing briefs and the joint appendix in *Doe v. Kidd II* is even more remarkable and only a well experienced Medicaid lawyer could prepare a joint appendix, a successful brief and reply brief in that amount of time.
21. Ms. Harrison frequently communicates with me to share recently decided Medicaid cases from the federal courts and I have found her to be a great resource in a field where few lawyers understand the “language,” let alone the alphabet of Medicaid law.
22. The requested fee in federal proceedings of less than \$1 million in a federal case like *Doe v. Kidd* that has gone on for more than a decade is reasonable and necessary to encourage

other private lawyers to defend the rights of disabled persons like Doe, who do not have funds to hire private counsel; and anything less will discourage them.

23. If costs of associated state actions were not recoverable under 42 U.S.C. 1988, the State could simply avoid compliance with the law by terminating eligibility.
24. In my experience, the federal Medicaid Agency, CMS, provides no oversight of federal Medicaid programs in respect to the minimum amount or minimum services furnished by a state. In its entire history CMS has never penalized a state for paying too little or not furnishing sufficient services in its Medicaid program. The manifest reason is, that every billions of dollars a state profits by skirting the minimum requirements of the Act for provider payments or services, is an equal billions of dollars saved by the federal government. Indeed, this conflict of interest was frankly reported to the Supreme Court in the *Douglas* cases by a host of former Secretaries of HHS, (Amicus Brief August 25, 2011, filed in *Douglas*, at page 25:

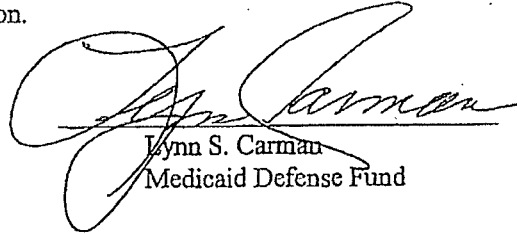
Finally, it bears noting that there is no realistic financial incentive for CMS aggressively to enforce § (30)(A)-quite to the contrary. Because [Federal Financial Participation] is a function of the funds the state actually expends reimbursing providers, state non-compliance with § 30(A) necessarily results in lower reimbursement rates, *thereby saving the federal government money*. See Moncrief, Assault on Litigation, *supra*, at 2341. In that framework, CMS is unlikely to enforce something like the Equal Access Provision [of § 30(A)], which would, in its violation, save federal money.

(Emphasis supplied).

Accordingly, due to lack of oversight, or conflicted oversight, by the federal government, litigation like *Doe v. Kidd* is useful and necessary, and was envisioned by Congress in enacting § 1988, to prevent States from accepting federal funds and failing to use them

for the intended purpose.

I have read this statement and I swear under penalty of perjury that it is true to the best of my knowledge and information.



Lynn S. Carman
Medicaid Defense Fund

October 22, 2013

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Lennie Mullis,	)	Docket No. 10-ALJ-08-0775-AP
	)	
Appellant,	)	
vs.	)	
	)	ORDER
South Carolina Department of Health and	)	
Human Services,	)	
	)	
Respondent.	)	
	)	

I. STATEMENT OF THE CASE

This matter is before the Administrative Law Court ("ALC" or "Court") in its appellate jurisdiction pursuant to S.C. Code Ann. § 1-23-600(D) (Supp. 2010). Lennie Mullis ("Appellant") appeals the final administrative decision of the South Carolina Department of Health and Human Services ("Respondent" or "SCHHS") to terminate Appellant as an approved provider of behavior support services under the South Carolina Mental Retardation/Related Disabilities Medicaid Waiver Program.

Upon careful review of this matter, considering the Record on Appeal, the briefs, and applicable law, this matter is reversed.

II. BACKGROUND

A. Factual Background

Appellant contracts with Respondent as an approved provider of behavior support services under the South Carolina Mental Retardation/Related Disabilities ("MR/RD") Medicaid Waiver Program.¹ Under the provisions of the contract, Appellant provides psychological counseling and behavioral support services to individuals with mental retardation and related disabilities. Also as part of her contract, Appellant, as an approved provider, is subject to periodic performance reviews. In July 2002, the South Carolina Department of Disabilities and Special Needs ("DDSN") sent a

¹ Appellant has thirty years of experience working with persons with developmental disabilities. She holds a B.S. degree in Psychology from Northeastern University and a M.S. degree in psychology from Florida Southern College. Appellant has been a Medicaid Waiver Provider since 1994.

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SC ADMIN. LAW COURT

memorandum to all providers informing them that a new quality assurance process was being implemented to evaluate providers' behavior support services under MR/RD waivers, and that the quality assurance process would include thirteen (13) criteria by which providers would be reviewed. A Quality Assurance review was performed in October 2008 to determine Appellant's compliance with the MR/RD waiver services standards. The process of selecting the cases to be reviewed involved randomly selecting five of Appellant's cases, and then selecting three of the five cases for review. Appellant's work on the three selected cases was evaluated based on the 13 criteria; and based on the results of the review, Respondent determined that Appellant failed to meet twelve (12) of the 13 criteria.

Respondent mailed a notice to Appellant on October 27, 2008 providing the results of the evaluation and requesting that Appellant take corrective action. Appellant submitted her corrective action plan on November 18, 2008.² A follow-up review was performed in 2010. For the follow-up review, two of Appellant's cases were selected at random, and a repeat review was performed on one of the samples evaluated during the 2008 review. The results of the follow-up review revealed that nine (9) of the 13 criteria were not met. Based on the results of the follow-up review, DDSN recommended to Respondent that Appellant's name be removed from the list of providers qualified to offer Behavioral Support Services.

B. Procedural Background

On May 18, 2010, DDSN recommended to Respondent that Appellant be terminated as an approved provider of Behavior Support Services under the MR/RD waiver program. Pursuant to DDSN's recommendation, Respondent notified Appellant on May 25, 2010 that it was terminating Appellant's contract as an approved provider. On June 2, 2010, Appellant requested an appeal of her termination. On June 11, 2010, DDSN sent a memorandum to all Service Coordinator Supervisors instructing that Appellant's authorization to provide Behavior Support Services be suspended immediately. Appellant subsequently voiced her concern over this letter, and DDSN sent a second memorandum on June 18, 2010 indicating that Appellant could continue to provide services pending the outcome of her appeal.

² In addition to submitting her plan of correction to DDSN, Appellant wrote a letter to the Director of Mental Retardation at DDSN, addressing her concerns with the October 2008 review. Appellant also wrote a second letter to the Director and requested that the reviewer (who had conducted the October 2008 review) not participate in her follow-up review because he had already reviewed her work on four different occasions. This request was denied.

In addition to requesting an appeal, Appellant requested several documents from Respondent she believed were relevant to her removal from the list of providers qualified to offer Behavioral Support Services. The hearing officer denied Appellant's discovery request.

The appeal was heard by a hearing officer on August 19, 2010.³ On September 20, 2010, the hearing officer issued a Final Administrative Decision affirming Respondent's decision to terminate its contract with Appellant.

On October 20, 2010, Appellant filed a notice of appeal with the ALC to challenge Respondent's Final Administrative Decision.

III. ISSUES ON APPEAL

1. Did the hearing officer err in holding the decision to terminate Appellant was not arbitrary and capricious and was this finding characterized by an abuse of discretion?
2. Did the hearing officer err in holding that Respondent can properly terminate Appellant pursuant to the terms of the non-contracted Medicaid provider agreement even when the termination relies on decisions and rules from privately contracted experts and a state agency other than the single state agency that administers the federal Medicaid program?
3. Was the hearing officer's decision clearly erroneous in view of the reliable, probative and substantial evidence on the record as a whole?
4. Did the hearing officer err in holding Appellant's constitutional right to procedural due process was not violated?
5. Did the hearing officer abuse her discretion by refusing to admit the 2005 ALC Order and the Roddy reviews into evidence and by refusing to grant Appellant's discovery request?

IV. STANDARD OF REVIEW

This Court's appellate review of final decisions of Respondent is governed by standards provided in S.C. Code Ann. § 1-23-380. See also S.C. Code Ann. § 1-23-600(E). Section 1-23-380 provides that this Court "may not substitute its judgment for the judgment of the [Respondent] as to the weight of the evidence on questions of fact." § 1-23-380(5). However, this Court, pursuant to § 1-23-380(5), may reverse or modify the decision if substantial rights of the appellant have been

³ During the hearing Appellant requested to admit two documents into the record: 1) an Administrative Law Court decision issued in 2005; and 2) reviews of provider Kim Roddy. Both of the requests to admit were denied by the hearing officer.

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 [Respondent];
- (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.

Id.; see also Lark v. Bi-Lo, Inc., 276 S.C. 130, 276 S.E.2d 304 (1981) (stating “[s]ubstantial evidence” is not a mere scintilla of evidence nor the evidence viewed blindly from one side of the case, but is evidence which, considering the Record as a whole, would allow reasonable minds to reach the conclusion that the administrative agency reached or must have reached in order to justify its action.”) Id. at 135, 276 S.E.2d at 306. “The findings of the agency are presumed correct and will be set aside only if unsupported by substantial evidence.” Hull v. Spartanburg County Assessor, 372 S.C. 420, 424, 341 S.E.2d 909, 911 (Ct. App. 2007) (citing Kearse v. State Health and Human Servs. Fin. Comm’n, 318 S.C. 198, 200, 456 S.E.2d 892, 893 (1995)). Accordingly, “[t]he ‘possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency’s finding from being supported by substantial evidence.’” Grant v. S.C. Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995) (citing Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm., 282 S.C. 430, 432, 319 S.E.2d 695, 696 (1984)).

Further, an abuse of discretion occurs when an administrative agency’s ruling is based upon an error of law, such as application of the wrong legal principle; or, when based upon factual conclusions, the ruling is without evidentiary support; or, when the trial court is vested with discretion, but the ruling reveals no discretion was exercised; or, when the ruling does not fall within the range of permissible decisions applicable in a particular case, such that it may be deemed arbitrary and capricious. State v. Allen, 370 S.C. 88, 94, 634 S.E.2d 653, 656 (2006) (application of standard to circuit court), citing Fontaine v. Peitz, 291 S.C. 536, 539, 354 S.E.2d 565, 566 (1987); see also Converse Power Corp., 350 S.C. 39, 47 564 S.E.2d 341, 345 (Ct. App. 2002), quoting Deese v. State Bd. of Dentistry, 286 S.C. 182, 184-85, 332 S.E.2d 539, 541 (Ct. App. 1985) (“A decision is arbitrary if it is without a rational basis, is based alone on one’s will and not upon any course of reasoning and exercise of judgment, is made at pleasure, without adequate determining principles, or

is governed by no fixed rules or standards.”).

V. DISCUSSION

In this matter, Appellant argues that Respondent erred in terminating her as a Qualified Provider for Behavior Support Services under the MR/RD Medicaid waiver program. In support of her argument, Appellant cites to documents in the record, various state and federal laws, and the policies of Respondent and DDSN. In response, Respondent argues that there is substantial evidence in the record to affirm the hearing officer’s decision.

A. Medicaid, generally

Medicaid is an optional state program created under Title XIX of the Social Security Act. It enables states to receive federal financial assistance specifically for the medical care of needy individuals. See 42 C.F.R. § 1396; Wilder v. Va. Hosp. Ass’n, 496 U.S. 498, 502 (1990); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007). States are not required to participate in Medicaid; however, if they choose to do so, they must comply with all federal Medicaid laws and regulations. Wilder, 496 U.S. 498; Doe, 501 F.3d at 351; see also Antrican v. Odom, 290 F.3d 178 (4th Cir. 2002) (“Although North Carolina may retain a special sovereignty interest in choosing whether to participate in the Medicaid program, once it elects to participate, it is not entitled to assert that interest to insulate itself from the requirements of the federal program.”), cert. denied, Odom v. Antrican, 537 U.S. 973 (2002). As a prerequisite to receiving federal assistance, a state must submit a detailed plan, referred to as the “State Plan,” to the Center for Medicare/Medicaid Services (“CMS”) for approval. 42 C.F.R. § 1396a.

In South Carolina, HHS is the state agency responsible for administering and supervising the state’s Medicaid programs. S.C. Code Ann. § 44-6-30(1); Doe, 501 F.3d at 351. HHS has contracted with DDSN to operate the MR/RD Medicaid waiver program; thus, DDSN is the agency responsible for the state’s treatment and training programs for people with mental retardation and related disabilities. Doe, 501 F.3d at 351. Accordingly, in some instances, such as the case at hand, DDSN can act as an agent for HHS. Id.

B. Qualified Provider, generally

The Appellant is a Qualified Provider for Behavior Support Services (“BSP”), which is a Medicaid reimbursable service run by DDSN and operated under the MR/RD Medicaid waiver program. Participants in the waiver program can purchase expertise to learn behaviors that are

appropriate and replace inappropriate behavior. This service is provided to individuals who live outside of an institution; and the professional is hired to work with the caretakers, not with the Medicaid recipients directly.

In order to become a provider, a person must be qualified and additionally, is subject to Quality Assurance Reviews using 13 review criteria established by DDSN. The Respondent contracts with the Center for Disability Resources ("CDR") at the USC School of Medicine to conduct the Quality Assurance Reviews. CDR in turn hires outside experts to assist with the quality assurance reviews. Once the reviews are completed, CDR provides the review results to the Director of the Division of Mental Retardation at DDSN who in turn communicates the review results to the BSP. If there are problems, the BSP is asked to submit a plan for correcting any noted deficiencies. Once the BSP submits a plan for correction, a follow-up review is conducted to again measure compliance with the 13 criteria.

When a provider comes up for review, CDR determines the location where the services are being provided and asks for a list of every service recipient. CDR then randomly selects 5 names from this list, and requests the complete files on the selected recipients. Subsequently CDR reduces the list down to 3 recipients to whom they will conduct a full quality assurance review. Thereafter three individuals review the material and perform the review which consists of on-site reviews, individual interviews with the service coordinator, interviews with the supervisor of the service at the residence, interviews with a workshop or work-site employee who works with the recipient, and a brief interview with the person receiving services. Each reviewer completes an individual report which is eventually merged into a summary report focusing on the 13 criteria. If a Provider does not meet 100% of the 13 criteria during the initial review, she may continue if she submits an acceptable plan of correction and has no negative findings on the follow-up review. There is no established rule that compliance must be in the 90% to 100% range, but compliance must be sufficient to show the service being purchased is what the caretaker is receiving. Each BSP is reviewed by the same standard: only those 13 criteria are used to measure quality and compliance. Quality assurance reviews are performed on every provider.

C. Hearing Officer's Decision

In the final administrative order, the hearing officer found and concluded that Appellant

“consistently failed to meet the required criteria in her Quality Assurance Reviews and demonstrated sub-standard work.” Thus, the hearing officer agreed with Respondent’s decision to terminate its contract with Appellant. In response, Appellant argues that the decision was arbitrary and capricious and is characterized by an abuse of discretion.

“A decision is arbitrary if it is without a rational basis, is based alone on one’s will and not upon any course of reasoning and exercise of judgment, is made at pleasure, without adequate determining principles, or is governed by no fixed rules or standards.” Deese v. State Bd. of Dentistry, 286 S.C. 182, 184-5, 332 S.E.2d 539, 541 (Ct. App. 1985). Furthermore, an “abuse of discretion occurs when the ruling is based on an error of law or a factual conclusion that is without evidentiary support.” Wright v. Craft, 372 S.C. 1, 34, 640 S.E.2d 486, 504 (Ct. App. 2006) (citing Menne v. Keowee Key Prop. Owners’ Ass’n, Inc., 368 S.C. 557, 568, 629 S.E.2d 690, 696 (Ct. App. 2006)).

I find in this instance that the hearing officer’s decision was an abuse of discretion. The record indicates that the criteria are subjective and arbitrary, the process used to summarize the individual reports and terminate a provider is arbitrary, and the final determination of whether a provider passes or fails the review is also arbitrary. During the review process, 3 cases are selected for review. Each case is then reviewed by one reviewer, and that reviewer measures and scores the qualified provider’s performance using the 13 criteria, and reports whether each criterion is met or unmet. The record substantiates Appellant’s claim that the 13 criteria used to measure the performance of providers are arbitrary and capricious. For example, one criterion measures whether an appropriate method has been used to analyze the intervention effect. This criterion is extremely subjective because it allows the reviewer complete discretion in determining whether the analysis method is “appropriate.” The criterion does not specify what type of analysis method must be used, and there is no policy in writing to guide reviewers in the review process. Furthermore, a Department witness testified that there is no formal protocol as to what type of functional assessment is appropriate or required and no examples of protocols are given to providers. The lack of objectivity in this criterion and in other criteria leads to decisions which are arbitrary and capricious because the criteria do not provide adequate determining principles or fixed rules or standards. Therefore, a decision based on these subjective criteria is based only on the reviewer’s will and subjective opinion about whether a method is “appropriate.”

Once the individual reports are completed, all three reports are merged together into a summary report. A Department witness testified that the provider cannot score a "yes" in the final summary report unless she scores a "yes" on that criterion in all three of the individual case reports. However, this "system" was not consistently followed in Appellant's review: Appellant received a "yes" on one of the three individual case reports for criteria 1, 5, 6, and 11, but still received a "yes" on the final summary report for these criteria. On the contrary, Appellant received a "yes" for criteria 4, 8, and 9 on two of the three individual reports, but didn't receive a "yes" for these criteria on the summary report. Thus, the process of summarizing Appellant's individual reports, which ultimately led to the decision to terminate Appellant was clearly arbitrary and capricious as it was "based alone on one's will," made "without adequate determining principles" and "governed by no fixed rules or standards." See Deese v. State Bd. of Dentistry, 286 S.C. 182, 184-85, 332 S.E.2d 539, 541 (Ct. App. 1985).

Additionally, the final determination of whether a provider failed the review and should be terminated is also arbitrary. A Department witness testified that DDSN has "not established a hard and fast rule" as to the percentage of compliance providers must meet in order to pass a review." She also testified that the review must "be sufficient to show that the service that we are purchasing is being provided" and "DDSN says whether it is sufficient or not." This testimony establishes that the decision to terminate Appellant was "governed by no fixed rules or standards," but was simply based on the will of DDSN who "says whether it is sufficient or not." Id.

Appellant was prejudiced by these errors: the errors, combined with the arbitrariness of Respondent's review and termination process, caused Appellant's work to be improperly reviewed and her certification as an approved provider of Medicaid services was improperly revoked.

D. Privately Contracted Experts

42 C.F.R. § 431.10 requires that a State Medicaid plan must "specify a single State agency established or designated to administer or supervise the administration of the plan." In South Carolina, Respondent is the single State agency given this statutory authority. Appellant argues that Respondent improperly delegated its authority – not only to another State agency (DDSN) – but also to private individuals, in violation of 42 C.F.R. § 431.10. Thus, Appellant argues that Respondent improperly delegated administrative discretion and the authority to issue policies, rules, and regulations to DDSN and other contracted, private individuals. I disagree.

In South Carolina, HHS is the state agency responsible for administering and supervising the state's Medicaid programs. S.C. Code Ann. § 44-6-30(1). HHS has contracted with DDSN to operate the MR/RD Medicaid waiver program, as provided for under 42 C.F.R. § 431.10:

(a) Basis and purpose. This section implements section 1902(a)(5) of the Act, which provides for designation of a single State agency for the Medicaid program.

(b) Designation and certification. A State plan must--

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

...

(e) Authority of the single State agency. In order for an agency to qualify as the Medicaid agency--

(1) The agency must not delegate, to other than its own officials, authority to--

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

The regulation clearly provides that Respondent may delegate some duties under the federal Medicaid program so long as Respondent does not give such agencies authority to make final, binding determinations upon Respondent or issue any policies or regulations on program matters. In this matter, there is no evidence in the record that Respondent delegated its authority to make a final determination with regard to Appellant's contractual status with Respondent. A recommendation was made regarding her status; however, Respondent retained the ultimate authority to make the final determination.

Appellant cites RCJ Medical Services, Inc. v. Bonta, 91 Cal.App.4th 986 (2001) as a distinguishable case from the present matter. However, I disagree. This case explicitly states that 42 C.F.R. § 431.10 "does not require states to use only one agency to carry out every task that is part of the State Plan." RCJ Medical, 91 Cal. App.4th at 1008. All that is required under the regulation is

for the single state agency – here, Respondent – “to administer or to supervise the administration of the plan.” Id. citing King by King v. Sullivan, 776 F.Supp.645, 656-657 (D.R.I. 1991) (emphasis in original). That is precisely what Respondent has done: while some of the functions within the Medicaid program have been delegated to DDSN, Respondent supervises the administration of the plan and retains ultimate authority with regard to final determinations.

E. Substantial Evidence

Appellant next argues that Respondent’s final decision was clearly erroneous in view of the reliable, probative and substantive evidence on the record as a whole. I agree.

A reviewing court may reverse the decision of an administrative agency “if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are . . . clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record.” S.C. Code Ann. § 1-23-380(A)(6) (Supp. 2008). Substantial evidence is “evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion that the administrative agency reached or must have reached in order to justify its decision.” Lark v. BiLo, Inc., 276 S.C. 130, 135, 276 S.E.2d 304, 306 (1981). Here, the hearing officer’s conclusion that Respondent’s decision “was not arbitrary and capricious” is clearly erroneous in view of the substantial evidence in the record. Specifically in this matter, when considering the record as a whole, the record is completely devoid of any evidence that would allow a reasonable mind to reach the conclusion that the review and termination process was not arbitrary and capricious. See generally Weaver v. S.C. Coastal Council, 309 S.C. 368, 423 S.E.2d 340 (1992) (administrative agency decision reversed when the record before the hearing officer was devoid of evidentiary support for the agency’s finding).

For the review process to meet the standards of S.C. Code Ann. 1-23-380(A)(6), it must be based on a fixed rule or standard. Deese, 286 S.C. 182, 332 S.E.2d 539; Hatcher v. S.C. District Council of Assemblies of God, Inc., 267 S.C. 107, 226 S.E.2d 253 (1976). Here, however, there is a total absence of consist and credible evidence in the record with regards to a fixed rule or standard by which Appellant was measured. Three of the Department’s witnesses were questioned as to the existence of a fixed rule or standard. Their testimony establishes that no fixed rule or standard exists. For example, a witness testified that the DDSN did not have a specific number or percentage which constituted a passing score. In addition, another Department witness would not specify the

minimal number of criteria a provider must meet to pass, but only testified that “[i]f somebody was missing one criteria, DDSN is not going to recommend that they be removed from the list.” Yet, a third Department witness completely contradicted the previous testimony when he testified that a provider must “meet all the criteria to pass.” As a result of the absence of credible evidence and consistent testimony as to what a provider is required to do to pass a review, the hearing officer’s conclusion that Appellant’s termination was not arbitrary and capricious was clearly erroneous.⁴

Section 1-23-280 also provides that a reviewing court may reverse an administrative agency’s decision if the Appellant has been prejudiced due to findings in the decision which are “clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record.” Here, at least one of the hearing officer’s findings is clearly erroneous: the order held that “DDSN has never had a BSP continue with only 1 out of 13 in compliance or 4 out of 13 in compliance such as in this case.” There is nothing in the record to support the finding that DDSN has never had a provider continue with 4 out of 13 in compliance.

Appellant was prejudiced by these errors because as a result of the errors and the arbitrariness of Respondent’s review and termination process, Appellant’s work was improperly reviewed and her certification as an approved provider of Medicaid services was improperly revoked.

F. Procedural Due Process

Appellant next argues that she was denied procedural due process in the review and termination process. Specifically, Appellant asserts that she has a protected property interest in the certification, and thus, she is required to have “a pretermination opportunity to respond and a post-termination procedure.” Ross v. MUSC, 328 S.C. 51, 66, 492 S.E.2d 62, 71 (1997). In response, Respondent does not challenge Appellant’s assertion that she has a protected property interest in the certification; however, it argues that she was provided all due process protections required by law.

“Procedural due process requirements are not technical, and no particular form of procedure is necessary.” Olson v. S.C. Dep’t of Health and Envtl. Control, 379 S.C. 57, 69, 663 S.E.2d 497,

⁴ The hearing officer also held that Appellant’s “failure to meet the required criteria in both the initial Quality Assurance Review and the follow-up Quality Assurance Review satisfies Respondent’s grounds for termination.” This holding is also erroneous because it is not based on any type of document or firm answer as to how many criteria must be met to pass the review. The hearing officer’s decision could not have been based on substantial evidence, because no consistent evidence exists as to the standard by which Appellant is measured. Further, the hearing officer failed to make a finding of fact as to how many criteria must be met. See Porter v. S.C. Pub. Serv. Comm’n, 333 S.C. 12, 22 n.3, 507 S.E.2d 328, 333 n.3 (1998) (the Court will not “*sua sponte* search the record for substantial evidence supporting a decision when an administrative agency’s order inadequately sets forth the agency’s findings of fact and reasoning”).

503 (Cl. App. 2008). “Rather, due process is flexible and calls for such procedural protections as the particular situation demands.” *Id.* at 69, 663 S.E.2d at 504. “The fundamental requirement of due process is the opportunity to be heard at a meaningful time and in a meaningful manner. *Id.* While a full evidentiary pretermination hearing is not required, “some kind of hearing is required prior to the discharge of an employee who has a constitutionally protected interest in employment.” *Ross v. MUSC*, 328 S.C. at 66, 492 S.E.2d at 71. As part of this pretermination hearing, Appellant is entitled to: “1) oral or written notice of the charges against him; 2) an explanation of the employer’s evidence, and 3) and opportunity to present his explanation.” *Id.* “To prevail on a claim of denial of due process, there must be a showing of substantial prejudice.” *See Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm’n*, 282 S.C. 430, 435, 319 S.E.2d 695, 698 (1984).

Furthermore, “[u]nder the law of the case doctrine, ‘a party is precluded from relitigating, after an appeal, matters that were either not raised on appeal, but should have been, or raised on appeal, but expressly rejected by the appellate court.’” *Sloan Const. Co., Inc. v. Southco Grassing, Inc.*, 395 S.C. 164, 169, 717 S.E.2d 603, 606 (2011) (citing *Judy v. Martin*, 381 S.C. 455, 458-59, 674 S.E.2d 151, 153 (2009) quoting *Bakala v. Bakala*, 352 S.C. 612, 632, 576 S.E.2d 156, 166 (2003)). “The law of the case applies both to those issues explicitly decided and to those issues which were necessarily decided in the former case.” *Id.* at 170, 717 S.E.2d at 606. The 2005 ALC Order addressed this very issue. In that order, the ALC determined that the Department’s procedures regarding the review and termination process were “fundamentally flawed and greatly increase the risk that a provider will be erroneously deprived of his or her property interest in continued certification.” Thus, the ALC found that “Appellant was not afforded procedural due process in the review and termination process.” The Department did not appeal the 2005 order, and it has not changed any part of its procedures in response to the Court’s 2005 Order. Thus, the law of the case in this matter remains that the Department’s procedures, as applied to Appellant, do not afford procedural due process in the review and termination process.

Accordingly, the hearing officer erred in holding that Appellant was provided a meaningful opportunity to be heard. Appellant was prejudiced by this error because as a result of the error, Appellant’s certification as an approved provider of Medicaid services was improperly revoked.⁵

⁵ Appellant further argues that she was not provided a pretermination opportunity to respond or answer Respondent’s contentions regarding the quality of her work because her name was removed for the approved provider list prior to the hearing. However, the record reflects that Appellant’s status as a behavior support provider remains

G. Requests to Admit and Discovery Request

The decision to admit or exclude evidence should be reversed on appeal if the Hearing Officer abused her discretion and if the Appellant has been prejudiced as a result. See Wright v. Craft, 372 S.C. 1, 33-34, 640 S.E.2d 486, 503-504 (Ct. App. 2006). "An abuse of discretion occurs when the ruling is based on an error of law or a factual conclusion that is without evidentiary support." Id. (citing Menne, 368 S.C. 557, 568, 629 S.E.2d 690, 696 (Ct. App. 2006)). Prejudice occurs if there is a "reasonable probability the [decision] was influenced by the challenged evidence or the lack thereof." Id. (citing Fields v. Reg'l Med. Ctr. Orangeburg, 363 S.C. 19, 26, 609 S.E.2d 506, 509 (2005)).

i. Provider Kim Roddy's Reviews

Appellant next argues that the hearing officer's denial of her request to admit Kim Roddy's reviews into evidence was based on an error of law. Appellant sought to admit the reviews to support her assertion that the review process is arbitrary. However, the hearing officer refused to admit the reviews because Ms. Roddy was not present to testify regarding the reviews. Hearsay is defined as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." Rule 801(c), SCRE. "The rule against hearsay prohibits the admission of evidence of an out-of-court statement to prove the truth of the matter asserted unless an exception to the rule applies." Watson v. State, 370 S.C. 68, 71, 634 S.E.2d 642, 644 (2006) quoting Dawkins v. State, 346 S.C. 151, 156, 551 S.E.2d 260, 262 (2001). Here, Ms. Roddy was not present to testify regarding the reviews, and the hearing officer properly ruled that the reviews could not come into evidence. ⁶

ii. 2005 Administrative Law Court Order

Appellant next argues that the hearing officer erred in denying her request to admit the 2005 ALC Order into evidence. At the hearing, Respondent objected to Appellant's attempt to enter the

uninterrupted. Although a June 11, 2010 DDSN memo informed DDSN supervisors that Appellant was to be removed for the approved provider list, a follow-up memorandum on June 18, 2010 informed the DDSN supervisors that the previous memo was incorrect; Appellant was immediately placed on the approved provider list pending the outcome of this appeal.

⁶ Notably, the hearing officer stated in her order that "DDSN has never had a [provider] continue with only 1 out of 13 in compliance or 4 out of 13 in compliance." However, no testimony was given during the hearing to substantiate this claim, and there is no document in the record to substantiate this statement.

2005 ALC Order into evidence and argued that the 2005 Order was “non-precedential” and “has no relevance” to the case at hand. The hearing officer sustained the Department’s objection. This ruling was based on an error of law because prior orders from the ALC can be relevant and precedential in certain circumstances. See 330 Concord St. Neighborhood Ass’n v. Campsen, 309 S.C. 514, 518, 424 S.E.2d 538, 540 (Ct. App. 1992) (holding that an administrative agency is generally not bound by the principle of stare decisis, but could be if the cases are not distinguishable and if the agency acts arbitrarily in failing to follow prior decisions)). Further, evidence is relevant if it has “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.” Rule 401, SCRE. The 2005 ALC Order is clearly relevant to the present matter. It involved the same parties and was in regards to the same issue—Respondent’s review and termination of Appellant. The Order is also relevant because it discusses shortcomings in Respondent’s review and termination process. The refusal to admit the Order was based on error of law and factual conclusions with no evidentiary support. Moreover, the record provides no support for the hearing officer’s decision that the Order was irrelevant.

Furthermore, the hearing officer acted arbitrarily and improperly in refusing to admit the 2005 ALC Order. Her decision was based on information improperly communicated by Dr. Lacy, the Associate Director of DDSN. Prior to the hearing, Dr. Lacy sent the hearing officer an *ex parte* email stating that, “I believe [the Appellant] wants to bring up a previous appeal, likely 6 years ago where her appeal for disenrollment was overturned by the [hearing officer]. It has nothing to do with the current issue.” This was in response to an *ex parte* email from the hearing officer which stated, “I need your input about this.” Thus, the hearing officer’s decision to exclude the 2005 ALC order was not only unsupported by the Record and based on an error of law, but was also based on Dr. Lacy’s improper opinion about the relevancy of the Order.⁷

iii. Requested Documents Related to Appellant’s Termination

⁷ Pursuant to Section 1-23-360, it is improper for “members or employees of an agency assigned to render a decision” to communicate, in connection with any issue of fact, with any person or party. It is also improper for the person assigned to render a decision to communicate, “in connection with any issue of law, with any party or his representative, except upon notice and opportunity for all parties to participate.” S.C. Code Ann. 1-23-360. However, communication is not improper if the communication only relates to procedural matters and does not discuss the merits of an issue. Holly Hill Farm Corp. v. U.S., 447 F.3d 258, 269 (4th Cir. 2006). Here, the communication between the hearing officer and Dr. Lacy clearly involved the merits of the discovery issue and the merits of the relevance of the 2005 ALC Order.

Appellant also argues that the hearing officer erred in refusing to grant Appellant's request for documents relevant to her termination. Appellant requested documents regarding the Department's involvement in the review and termination process. Appellant believed the documents were relevant because they provide support for her claims that the review and termination process is arbitrary and capricious and that it violates 42 C.F.R. § 431.10. The hearing officer denied Appellant's request and based this denial on Dr. Lacy's *ex parte* communication. Again, this denial of Appellant's request to admit was based on an error of law because it relied upon Dr. Lacy's improper opinion regarding the relevancy of the documents.

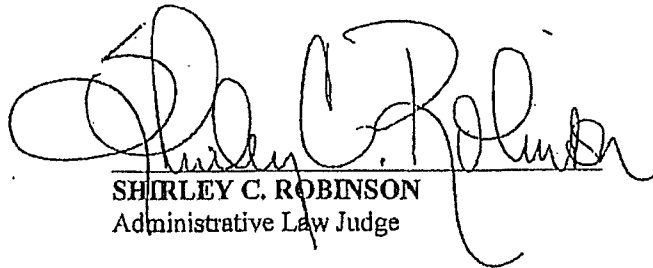
All of these errors prejudiced Appellant because they substantially hindered her ability to present evidence as to why her termination was improper and arbitrary. Cf. Ross, 328 S.C. 51, 492 S.E.2d 62 (finding that denial of a discovery request did not prejudice party requesting discovery when the denial did not substantially hinder his ability to respond to the charges against him which led to his termination).

ORDER

For the reasons set forth above,

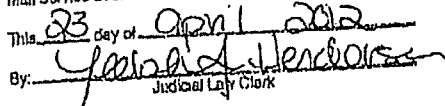
IT IS HEREBY ORDERED that Respondent's decision to terminate Appellant as a Qualified Provider for Behavior Support Services under the South Carolina MR/RD Medicaid waiver program is **REVERSED**.

AND IT IS SO ORDERED.


SHIRLEY C. ROBINSON
 Administrative Law Judge

April 23rd 11, 2012
 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 23 day of April, 2012
 By: 
 Judicial Law Clerk