

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

Case No. 2013-002415

Brook Waddle Appellant,

v.

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

AMENDED INITIAL BRIEF OF PLAINTIFF

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I. Statement of Issues on Appeal.

- 1. The hearing officer and the lower court exceeded their authority and erred as a matter of law by dismissing Appellant's request for a fair hearing in violation of 42 C.F.R. 431.223, because Appellant did not request dismissal in writing and she did not fail to appear at a scheduled hearing. R. at 6.**
- 2. The hearing officer and the lower court exceeded their authority and violated Appellant's statutory rights contained at 42 U.S.C. 1396a(a)(3) and her constitutional right to due process guaranteed in the United States Constitution by refusing to provide an evidentiary hearing, instead basing her decision on evidence not introduced at an evidentiary hearing in violation of 42 C.F.R. 431.244(a).**
- 3. The hearing officer and the lower court violated 42 C.F.R. 431.240 by ignoring Appellant's request for an independent medical assessment of the need for the oximeter cable (R. at 8), which should have been provided at the expense of the State, because the hearing officer considered it necessary to have a medical assessment other than that of the individual who made the original determination. R. at 8.**
- 4. The hearing officer and the lower court exceeded their authority and violated Appellant's constitutional due process rights and the clear and unambiguous notice requirements of 42 C.F.R. 431.210 which require a written notice that (1) explain the agency's reason for denying payment for the oximeter cable and (2) identify the specific regulation or change in law that supported the agency's decision not to pay for the cable.**
- 5. DHHS has violated the Americans with Disabilities Act by failing to provide the reasonable accommodations of paying for an oximeter cable that is needed to allow Appellant to remain in the least restrictive setting and Respondent failed to meet its burden under the ADA of proving that paying for the oximeter cable would fundamentally alter the State's system. R. at 6 and 7.**

II. Standard of Review.

This Court may reverse or modify the agency's 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.

"Statutory interpretation is a question of law." *Hopper v. Terry Hunt Constr.*, 373 S.C. 475, 479, 646 S.E.2d 162, 165 (Ct.App.2007). This court may decide matters of law with no particular deference to the lower court. *Pressley v. REA Constr. Co.*, 374 S.C. 283, 287-88, 648 S.E.2d 301, 303 (Ct.App.2007). Particularly, in a case raising a novel question of law regarding the interpretation of a statute, the appellate court is free to decide the question with no particular deference to the lower court. *I'On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 411, 526 S.E.2d 716, 719 (2000) (citing S.C. Const. art. V, §§ 5 and 9 ; S.C.Code Ann. §§ 14-3-320 and -330 (1976 & Supp.2005), and S.C. Code Ann § 14-8-200 (Supp.2005)); *Osprey, Inc. v. Cabana Ltd. Partnership*, 340 S.C. 367, 372, 532 S.E.2d 269, 272 (2000) (same); *Clark v. Cantrell*, 339 S.C. 369, 378, 529 S.E.2d 528, 533 (2000) (same). "The appellate court is free to decide the question based on its assessment of which interpretation and reasoning would best comport with the law and public policies of this state and the Court's sense of law, justice, and right." *Sloan v. South Carolina Bd. of Physical Therapy Examiners*, 370 S.C. 452, 636 S.E.2d 598 (S.C. 2006).

III. Statement of the Case.

The subject of this appeal is DHHS' January 9, 2013 denial of payment for an oximeter cable. R. at 9 and 13. In 2007, Appellant commenced an appeal alleging that DHHS failed to provide necessary medical services and equipment and those proceedings have been ongoing in the Executive Branch for more than seven years. The lengthy history of those proceedings is described in *Waddle v. DHHS*, Order dated November 19, 2013 at 1 to 3. Exhibit 1. A final state

administrative order that is reviewable by the Judicial Branch has never been issued in that appeal that is now more than seven years old.¹

But, while Appellant's 2007 appeal was pending at DHHS and before the hearing officer issued an order on that 2007 appeal, DHHS denied Appellant's request for payment for an oximeter cable on January 9, 2013. R. at 14. The oximeter cable is required to measure Appellant's oxygen level to determine whether oxygen needs to be administered. R. at 9. The notice sent to Appellant states that payment for this equipment was denied because DHHS' contractor, Apria, did not provide its other contractor, KePro, with "supporting clinical information." R. at 14. The notice of denial did not contain the regulation or the change in law supporting the denial, as is required by 42 C.F.R. 431.210. R. at 14. On January 30, 2013, Appellant appealed the denial of payment for the oximeter cable and asked that the record in the 2007 appeal be supplemented "with this latest denial." R. at 13.

Instead of supplementing the record in the ongoing 2007 appeal, DHHS treated the denial of funding for the oximeter cable as a totally new appeal. A new hearing officer was appointed who issued a "Pre-hearing Conference Order" on February 5, 2013. R. at 11. Instead of scheduling a hearing on the merits of Appellant's case, this order required the parties to confer and required DHHS to provide the hearing officer with a "summary of issues" and to inform the hearing officer whether a resolution might be reached. Id. The order required Petitioner's attorney to file a "statement of intention to continue the appeal process and to attend a Fair

¹ DHHS filed a motion to reconsider which was denied by the hearing officer in that 2007 appeal. Exhibit 2. Order of Elizabeth Hutto dated December 23, 2014. That appeal is presently pending in the Administrative Law Court.

Hearing.” R. 11. The parties conferred, as required by the order. R. at 9.

DHHS advised the hearing officer by letter on March 19, 2014 that the payment for the oximeter cable was denied because DHHS’s agent Apria did not provide DHHS’s agent KePro with “supporting clinical information and a prescription for the device” within 48 hours. R. at 9. DHHS’ attorney deferred to Appellant’s counsel “to submit to the hearing officer any additional issues she wishes to raise at the hearing.” Id.

Also on March 19, 2013, Appellant submitted a three page Response to the hearing officer in response to this interlocutory order. R. at 6. This Response demonstrated to the hearing officer that Appellant intended to pursue the appeal and she requested reasonable accommodations that would allow her to participate effectively in the hearing. R. at 6 and 7. No reasonable person could possibly interpret this Response as indicating that Appellant was abandoning her appeal. Appellant requested that the hearing officer obtain an independent medical assessment to review DHHS’s denial of the oximeter cable at the expense of the State. R. at 8. Appellant incorporated by reference in this Response all allegations made during the course of the proceedings in the appeal filed in 2007 and specified her the grounds for her appeal. R. at 6.

The hearing officer was not satisfied with this Response. R. at 5. She “extended the due date” until April 2, requiring Appellant to provide documentation of the medical necessity for the oximeter cable. R. at 5. But Appellant had asked the hearing officer to provide a medical assessment and a federal regulation required her to do so at government expense if she felt that such assessment was necessary. Then, instead of scheduling a hearing, on April 4, 2013, the

DHHS hearing officer issued an order dismissing Brook's appeal. R. 1. The hearing officer dismissed Appellant's appeal without responding to her request for an independent medical assessment. R. at 8.

Appellant filed a notice of appeal in Administrative Law Court and filed an initial brief. ALC Brief of Appellant. Instead of filing a brief, as required by SCALC Rule 37, Respondent filed a Motion to Dismiss in the Administrative Law Court. ALC Motion to Dismiss and ALC Order dated October 11, 2013 at 4. To the knowledge of counsel neither the Rules applicable to "Matters Heard on Appeal from Final Decisions of Certain Agencies" nor the Administrative Procedures Act authorize the Administrative Law Court to dismiss a case based on such a motion, except for ALC Rule 38 which applies only to a party failing to comply with the ALC's Rules. ALC Rules 33 to 41. But there is no allegation in this case that Appellant failed to comply with any rule of the Administrative Law Court. That court, as an Executive Branch agency, is obligated to comply with its own rules requiring the State to file a brief in this case and to comply with federal law in the administration of the Medicaid program. 42 C.F.R. 431.223 prohibits the dismissal of a fair hearing appeal by any state entity without providing an evidentiary hearing where the appellant has an opportunity to present witnesses and to cross examine adverse witnesses, except where the recipient requests dismissal in writing or fails to appear at a scheduled hearing.

The Administrative Law Court improperly dismissed Appellant's appeal without requiring DHHS to file a brief meeting the requirements of ALC Rule 37. The ALC order dismissing Appellant's appeal was received by Appellant's counsel on October 15, 2013. *Id.* Appellant filed this appeal in the South Carolina Court of Appeals on November 12, 2013.

IV.

Statement of the Law

Medicaid is a “cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals.” *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 502, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990).^[1] The federal and state governments share the cost of Medicaid, but each state government administers its own Medicaid plan. *See Conn. Dep’t of Soc. Servs. v. Leavitt*, 428 F.3d 138, 141 (2d Cir.2005). State Medicaid plans must, however, comply with applicable federal law and regulations. *Doe v. Kidd I*, 501 F.3d 348, 351 (4th Cir. 2007) citing *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 502, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). (“Once a state elects to participate in the program, it must comply with all federal Medicaid laws and regulations.” *Id.*) *See also* 42 U.S.C. § 1396c; 42 C.F.R. § 430. Any state that elects to participate in the Medicaid program must designate “a single State Agency” to administer— or to supervise the administration of— the state’s Medicaid plan. *See* 42 U.S.C. § 1396a(a)(5). In South Carolina, the South Carolina Department of Health and Human Services (DHHS) is the Single State Agency responsible for the administration of the program. *Doe v. Kidd I* at 351. Although the State agency may delegate to other entities the performance of certain responsibilities, *see* 42 C.F.R. § 431.10(e), the State agency must (1) “[h]ave methods to keep itself currently informed of the adherence of local [entities] to the State plan provisions and the agency’s procedures for determining eligibility,” and (2) “[t]ake corrective action to ensure their adherence,” 42 C.F.R. § 435.903.

The Medicaid Act requires that states electing to participate in the Medicaid program

must grant "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." 42 U.S.C. § 1396a(a)(3).

The Code of Federal Regulations requires explicit information to be contained in notices provided pursuant to 42 U.S.C. 1396a(a)(3). The notice must be in writing and it must contain (1) the reasons for the intended action; and (2) the specific regulations that support, or the change in federal or state law that requires the action. 42 C.F.R. 431.210(b) and (c). Where such notice is not provided at least 10 days before the adverse action, services must not be reduced or terminated pending the fair hearing decision. 42 C.F.R. 431.211 and 431.230. Services must be reinstated where advance notice meeting these requirements is not provided. 42 C.F.R. 431.231

A hearing on the merits must be provided to any applicant who requests it because she believes the agency has taken an action erroneously or where a claim is denied or not acted upon with reasonable promptness. 42 C.F.R. 431.220. States are prohibited from dismissing a fair hearing appeal without providing an evidentiary hearing except in two extremely limited circumstances. 42 C.F.R. 431.223. One is where the recipient withdraws the request in writing, and, two, where the participant fails to appear at a scheduled hearing without good cause. *Id.*

CMS regulations require the hearing officer to base decisions “exclusively on evidence introduced at the hearing.” (Emphasis added.) 42 C.F.R. 431.244(a). The decision must identify the regulations supporting the decision, the reasons for the decision and the supporting evidence (which must have been introduced at the hearing). 42 C.F.R. 431.244(d) and (e). The Medicaid recipient must be allowed to bring witnesses to the evidentiary hearing, to present argument

without undue interference and to question or refute testimony or evidence. 42 C.F.R. 431.242.

The recipient must be given an opportunity to confront and cross-examine adverse witnesses, which simply cannot occur when a hearing is not provided. 42 C.F.R. 431.242(e).

42 C.F.R. 431.244(f) requires that the State agency "must take final administrative action ... [ordinarily, within 90 days" of the date a fair hearing is requested. *See* 42 C.F.R. § 431.244(f)(1)(ii) (" regulation"). In *Shakhness v. Berlin*, the Second Circuit held that:

...the regulation's 90-day requirement 'merely further defines or fleshes out the content' of the right to 'an opportunity' for Medicaid fair hearings, such that Plaintiffs have a right— enforceable under § 1983— to final administrative action "[ordinarily, within 90 days" of their request, *see* 42 C.F.R. § 431.244(f)."

689 F.3d 244, 254 (2d Cir. 2012). That court held that:

We further conclude that the right to an opportunity for Medicaid " fair hearings" includes a right to a decision following such hearings. That being so, we have little difficulty concluding that the regulation's 90-day requirement " merely further defines or fleshes out the content of that right." *See Harris*, 127 F.3d at 1009.

Id. at 256.

In addition to the specific requirements contained in 42 C.F.R. 431.200 et. seq., the state's Medicaid fair hearing system must be in compliance with all of the due process requirements the United States Supreme Court set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970). As the Second Circuit discussed in *Shakhnes*:

...*Goldberg* says 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, 90 S.Ct. 1011 (emphasis added). In addition, the *Goldberg* Court emphasized that " an impartial decision maker is essential." *Id.* We see little reason why this would be so unless the right to a fair hearing includes the right to a decision.^[8]

Supra at 256.

In addition to meeting all of the requirements of the Medicaid Act, DHHS is required by the Americans with Disabilities Act (ADA) and *Olmstead*, as well as state law, to provide services in the least restrictive environment. *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007), citing *Olmstead v. L.C.* 527 U.S. 581 (1999); S.C.Code Ann. § 44-20-20 (2006). The United States Supreme Court has determined that the burden of proving whether an action would cause a fundamental alteration under the ADA lies with the State. *Olmstead* at 603. Once a qualified individual proves his *prima facie* case in an action brought under the ADA, i.e. demonstrates that (1) he is a qualified person with disabilities, as defined in the ADA, (2) the State has determined that community based treatment is appropriate and (3) he does not oppose living in the community, then the burden shifts to the State to prove that providing the requested service or equipment would require a “fundamental alteration” in the nature of its programs. *Olmstead*, 527 U.S. at 604.

V. Argument

- 1. The hearing officer and the lower court exceeded their authority and erred as a matter of law by dismissing Appellant’s request for a fair hearing in violation of 42 C.F.R. 431.223, because Appellant did not request dismissal in writing and she did not fail to appear at a scheduled hearing. R. at 6.**

Federal regulations clearly and unambiguously specify very limited circumstances in which a State may dismiss a Medicaid recipient’s fair hearing appeal. The applicable regulation contained at 42 C.F.R. 431.223, titled “Denial or dismissal of request for a hearing” provides that:

The agency may deny or dismiss a request for a hearing if-

- (a) The applicant or beneficiary withdraws the request in writing; or

- (b) The applicant or beneficiary fails to appear at a scheduled hearing without good cause.

The hearing officer's order fails to mention or rely upon this, or any other federal statute or regulation. Likewise, the Administrative Law Court failed to address 42 C.F.R. 431.223, which applies to it as an Executive Branch agency of the State. Instead, the hearing officer relied upon a state regulation, DHHS Regulation 126-154 and the Administrative Law Court improperly upheld that decision. DHHS Regulation 126-154 provides that:

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.

The hearing officer exceeded her statutory authority by relying upon a state regulation which contradicts not only the clear and unambiguous regulation of CMS, the federal agency authorized by Congress to administer the Medicaid program, but it also conflicts with the agency's own regulation which states:

§ 126-399. Conflict Between State and Federal Regulations

When the requirements of the State and the Federal regulations are not in agreement, the requirements of the Federal regulations shall prevail.

In 42 U.S.C. 1396a(a)(3), Congress clearly and unambiguously mandated that DHHS 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;

Federal regulations contained at 42 C.F.R. 431.223 authorize the State to deny or dismiss a

hearing under limited circumstances, none of which that are not present in this case:

§ 431.223. Denial or dismissal of request for a hearing

The agency may deny or dismiss a request for a hearing if-

- (a) The applicant or beneficiary withdraws the request in writing; or
- (b) The applicant or beneficiary fails to appear at a scheduled hearing without good cause.

This requirement is not complicated or hard to understand. It is not rocket science. The State must simply provide the recipient an evidentiary hearing meeting the requirements clearly set forth in 42 C.F.R. 200 et seq., then make a decision based on the evidence presented at the hearing. Likewise, 42 C.F.R. 431.244(a) could not be more clear in requiring that “Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing.” When a Medicaid participant has not been provided an evidentiary hearing, it is impossible to meet the federal requirement that the decision must be based entirely on evidence introduced at the hearing. Appellant did not request, in writing or otherwise, that her appeal be dismissed and she never failed to appear at a scheduled hearing - the hearing officer refused to even schedule a hearing.

Appellant’s rights have been prejudiced by Respondent’s violations of federal law, the hearing officer and the Administrative Law Judge exceeded the statutory authority of the Executive Branch and the decision to dismiss Appellant’s appeal was made upon unlawful procedure. The act of dismissing Appellant’s “fair hearing” was arbitrary and capricious and these Executive agencies denied Appellant’s constitutional right to due process, as will be discussed in more detail below. Appellant requests that this honorable Court reverse the decision

of these Executive Branch agencies and that they be required to comply with federal law in the administration of the Medicaid program.

Appellant requests an order prohibiting Respondent from terminating services prior to providing an evidentiary hearing, paying for the oximeter cable and finding that she is the prevailing party in this appeal. Appellant requests a finding that the State acted without substantial justification and that the court award legal fees pursuant to S.C. Code of Laws 15-77-300. Such an award is appropriate and just in this case because Appellant contested state action where the agency acted without substantial justification in pressing its claim to deny critical medical equipment by dismissing Appellant's request for a fair hearing and there are no special circumstances that would make the award of attorney's fees unjust. Since the DHHS hearing officer and the Administrative Law Judge willingly and knowingly refused to provide an evidentiary hearing and, in any event, it is unclear whether either Executive tribunal has the authority to award or deny fees under S.C. Code of Laws 15-77-300, Appellant requests that this Court set forth in its order the correct procedure in Medicaid appeals for awarding fees pursuant to that statute.²

2. **The hearing officer and the lower court exceeded their authority and violated Appellant's statutory rights contained at 42 U.S.C. 1396a(a)(3) and her constitutional right to due process guaranteed in the United States Constitution by refusing to provide an evidentiary hearing, instead basing their decisions on evidence not introduced at an evidentiary hearing in clear violation of 42 C.F.R. 431.244(a).**

Elizabeth Hutto, who is now the Deputy Director of DHHS, in charge of Eligibility,

² S.C. Code § 15-77-310 provides that "The party shall petition for the attorney's fees within thirty days following final disposition of the case. The petition must be supported by an affidavit setting forth the basis for the request." But it does not specify what "court" has the authority to award fees in an action brought for violation of the Medicaid Act.

Enrollment and Member Services, was the hearing officer who heard Appellant's appeal in October of 2012 and issued orders on November 19, 2013 and December 23, 2013. Exhibits 1 and 2. Ms. Hutto described in her November 19, 2013 order the due process rights of Medicaid participants as follows:

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)...Federal regulations require that the notice of adverse action must 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.

Exhibit 1. Order dated November 19, 2013 at 25. That order describes the procedure that DHHS must follow to continue benefits during an appeal. *Id.* at 26. She found that DHHS "violated Petitioner's due process rights in enforcing its waiver reductions against her during the pending appeal." *Id.* at 30.

As discussed above in this brief, 42 C.F.R. 431.244(a) required the hearing officer and the Administrative Law Court to base their decisions exclusively on evidence introduced at the hearing. Those decisions simply could not possibly have been based exclusively on evidence presented at a hearing - without providing a hearing. Appellant's constitutional rights to due process were egregiously denied by the agency and the Administrative Law Court. The agency and the Administrative Law Court violated the Supremacy Clause and the Fourteenth Amendment of the United States Constitution by refusing to provide an opportunity for Appellant to be heard on her claim.

The United States Court of Appeals for the Fourth Circuit has addressed the issue of the requirements for notice and a hearing under the Medicaid Act and that Court's opinion is binding

on DHHS and the Administrative Law Court in Medicaid appeals. In *K.C., by and through Africa H. v. Shipman*, the district court granted a preliminary injunction to severely disabled plaintiffs on their claims that the North Carolina State Medicaid Agency violated their rights under the Medicaid Act and the Due Process Clause of the Fourteenth Amendment when the State reduced their health care services without providing notices meeting the requirements of 42 C.F.R. 431.210 and an opportunity for a hearing. Case No. 12-1575 (4th Cir. May 10, 2013). The district court ruled in that case that plaintiffs were entitled to the notice and appeal rights provided for by the Medicaid statute and the Fourteenth Amendment and that the defendants had failed to comply with those requirements. *Id.* at 111. (In district court, the case was captioned *L.S. v. Delia*, 5:11-CV-354-FL (NCED March 29, 2012)) The United States Court of Appeals for the Fourth Circuit denied the State's appeal of the district court's decision, upholding the findings of the district court judge. Case No. 12-1575 (4th Cir. May 10, 2013).

The district court in that case recognized that: "The Medicaid Act requires participating states and managed care entities to provide each Medicaid recipient with adequate written notice and an opportunity for an impartial hearing before services are denied, reduced or terminated. §§ 1396a(a)(3) and 1396u-2(a); 42 C.F.R. §§ 431.200 and 438" and that federal approval of the State's Medicaid Plan "specifies that defendant Delia must provide the opportunity for a fair hearing pursuant to federal regulations, 42 C.F.R. § 431.200 subpart E, to every waiver participant whose services are denied, suspended, reduced, or terminated. 42 C.F.R. § 431.200(a)." In ruling that the defendants violated the Medicaid participants' rights under federal law and due process, the North Carolina federal district court held that:

... plaintiffs were entitled to the notice and appeal rights outlined in the Medicaid

regulations, cited above, as well as under general principles of due process. See *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 786-87 (1980); *Goldberg v. Kelly*, 397 U.S. 254, 269-71 (1970); *McCartney ex rel. McCartney v. Cansler*, 608 F.Supp.2d 694, 699 (E.D. N.C. 2009)."

Id. The district court in North Carolina also ruled that:

...plaintiffs are likely to succeed on the merits on their claims that the same actions violated plaintiffs' due process rights under the Fourteenth Amendment. Plaintiffs have set forth the applicable law in detail, including the Supreme Court decision in *Goldberg*, which required that welfare recipients have timely and adequate notice detailing the reasons for proposed termination, that the opportunity to be heard be tailored to the capacities and circumstances of those to be heard, an opportunity to confront and cross-examine the witnesses relied on by the opposing side, and an impartial decision maker. 397 U.S. at 268-71.

Id. Further, the district court recognized that: "Additionally, the public interest always lies with upholding the law and having the mandates of the Medicare Act and due process enforced."

Appellant's case also presents a matter of great public concern and these violations are bound to continue unchecked unless this Court upholds the due process rights of severely disabled Medicaid waiver participants who do not have access to the arsenals available to the State.

In the present case, it is undisputed that the hearing officer and the Administrative Law Court refused to grant Appellant's request for a fair hearing. The requirement to provide an evidentiary hearing is clear and unambiguous and there is no doubt but that the agency and the Administrative Law Court knowingly ignored Appellant's constitutional rights to due process by failing to provide the requisite hearing. This is not an isolated case.

These same actors violated the right of Peter Brown to an evidentiary hearing through similar diversionary tactics and this Court ordered DHHS to provide Peter with a hearing on the merits of his case in 2011. *Peter Brown v. DHHS*, 393 S.C. 11, 709 S.E.2d 701, 705. (S.C.App. 2011). But, two years later, DHHS again dismissed Peter's appeal over his objections without

providing an evidentiary hearing and his appeal is pending in this court and in an action filed in the federal district court. Exhibit 3. See *Peter B. v. Sanford*, Case No. 6:10-767 (DCSC March 7, 2013).

The agency should be enjoined from reducing Appellant's services (including durable medical equipment) without providing an evidentiary hearing required by 42 U.S.C. 1396a(a)(3), now and in the future, as these violations are subject to repetition, yet these Executive Branch agencies have evaded review by the Judicial Branch.

For the reasons set forth above, Appellant prays for an order enjoining DHHS from reducing or terminating services (including durable medical equipment) prior to providing proper notice and an evidentiary hearing on the merits and finding that she is the prevailing party in this appeal. Appellant prays for an order finding that the State acted without substantial justification and for an award of legal fees.

3. **The hearing officer and the lower court violated 42 C.F.R. 431.240 by ignoring Appellant's request for an independent medical assessment of the need for the oximeter cable (R. at 8), which should have been provided at the expense of the State, because the hearing officer considered it necessary to have a medical assessment other than that of the individual who made the original determination. R. at 8.**

On March 27, 2013, ignoring Appellant's March 19, 2013 written request for an independent medical assessment, the hearing officer improperly placed the obligation to provide "documentation of the medical necessity of the cable" on Appellant. The hearing officer shifted to the Appellant, who cannot lift her arms or move her legs and cannot even speak, the burden of obtaining, at the recipient's expense, an independent medical assessment in violation of 42 C.F.R. 431.240(b). Exhibits 1 and 2. That clearly violated that federal regulation, which requires that:

If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and *if the hearing officer considers it necessary to have a medical assessment* other than that of the individual involved in making the original decision, such a medical assessment must be obtained at agency expense and made part of the record. (Emphasis added.)

This federal regulation is not difficult to understand and it places the burden on the State to obtain and pay for an independent medical assessment where, as in this case, (1) the hearing involves medical issues such as those concerning a diagnosis or a review team's decision, and (2) the hearing officer considers another medical assessment to be necessary. With those conditions met, the federal regulations provide that the assessment must be obtained at agency expense and must be made part of the record. Instead, the hearing officer dismissed Appellant's appeal in violation of a multitude of federal regulations and Appellant's due process rights. The hearing officer erred as a matter of law and exceeded her authority by placing this burden on Appellant, a severely disabled quadriplegic Medicaid participant who struggles each and every day just to stay alive and breathing after DHHS illegally and repeatedly reduced her services while her 2007 appeal has been pending for seven years. Exhibits 1 and 2. In her November 19, 2013 order, now Deputy Hutto (who was then a hearing officer) described Appellant as follows:

The medical records review conducted by the Respondent and the testimony of witnesses for both parties indicate that the Petitioner is 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

Exhibit 1, Order dated November 19, 2013 at 24.

42 C.F.R. 431.240 means something. This requirement was not included in the federal regulations for no reason at all. It was included in those regulations by the federal agency

authorized by Congress to administer the federal Medicaid program after publication in the federal register and opportunity for public comment. That federal regulation says that the hearing officer “must” obtain an independent medical assessment, it does not say “may.” CMS understood that impoverished Medicaid recipients do not have money to pay for expert opinions and that federal agency instructed the States that when a hearing officer determines that a medical assessment is necessary, the hearing officer must obtain the assessment at State expense. This responsibility cannot be met by a hearing officer sending an email saying that she did not like Appellant’s Response to the hearing officer’s (illegal) interlocutory order.

The intentional violation of this requirement is a matter of great public concern. Medicaid waiver participants are the most disabled and vulnerable citizens of our state and they must, by definition, be impoverished in order to qualify for Medicaid benefits. This violation is subject to repetition, yet it has evaded review again and again, where Appellant’s services have been reduced without medical justification. Exhibit 1. Appellant requests an order requiring DHHS to obtain an independent medical assessment at government expense when requested by a recipient prior to terminating or reducing services in this and all future Medicaid appeals in which the hearing officer determines that an additional medical assessment is needed.

Appellant prays for an order finding that she is the prevailing party on this issue, that the State acted without substantial justification and for legal fees.

4. **The hearing officer and the lower court exceeded their authority and violated Appellant’s constitutional due process rights and the clear and unambiguous notice requirements of 42 C.F.R. 431.210 which require a written notice that (1) explain the agency’s reason for denying payment for the oximeter cable and (2) identify the specific regulation or change in law that supported the agency’s decision not to pay for the cable.**

Respondent's notice was defective in this case and this violation of 42 C.F.R. 431.210 is subject to repetition, yet this violation also evaded review again and again with this same Appellant. Deputy Hutto of DHHS (who was then a hearing officer) found in her Order issued on November 19, 2013 the following violations:

Referring to the notice dated March 14, 2007, Ms. Hutto found that "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. Order at 7.

As to the notice dated March 29, 2007, Ms. Hutto stated: "Again, no statute or regulations were cited on this notice not was there any justification or analysis regarding whether the cost for this care would be greater than the cost of a nursing home...This notice made no mention of continued benefits pending appeal." Order at 7 and 8.

According to that order, the denial notices sent to Appellant upon discharge from the hospital in 2007 "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. Order at 22. The reasons for the denials were "erroneous" according to the uncontradicted testimony of the DHHS witness. Id. While Appellant's appeal was pending, Appellant's "services were improperly reduced several times" and these reductions "occurred without notice and the opportunity to appeal." Id.

According to the hearing officer, in July, 2008, when DHHS reduced Appellant's benefits while her 2007 appeal was pending: "There is no notice in the record regarding this service reduction." Order at 9 and 22.

Appellant's services were again reduced "improperly" in July, 2009, while her 2007 appeal was pending. Id. at 11. Hearing Officer Hutto stated in her November 19, 2013 order that: "There is no notice in the record regarding this reduction." Order at 9 and 10. The hearing officer found that "The Respondent again failed to provide proper notice." Id. at 22.

Appellant requests an order finding that Respondent's notice was defective, these violations have been longstanding and that DHHS should be enjoined from terminating or reducing services without providing written notices meeting all of the requirements of 42 C.F.R.

431.210. Appellant requests that this Court rule that Appellant is the prevailing party on this issue, that the state Executive Branch tribunals and DHHS were not substantially justified in failing to provide proper notice and that Appellant's legal fees be paid pursuant to S.C. Code of Laws 15-77-300.

5. **DHHS has violated the Americans with Disabilities Act by failing to provide the reasonable accommodations of paying for an oximeter cable that is needed to allow Appellant to remain in the least restrictive setting and Respondent failed to meet its burden under the ADA of proving that paying for the oximeter cable would fundamentally alter the State's system. R. at 6 and 7.**

Respondent is required by the ADA and *Olmstead*, as well as state law, to provide services in the least restrictive environment. *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007), citing *Olmstead v. L.C.* 527 U.S. 581 (1999); S.C.Code Ann. § 44-20-20 (2006). The United States Supreme Court has determined that the burden is on the State to prove that a requested accommodation would cause a fundamental alteration under the ADA once the disabled person has met her *prima facie* case by demonstrating that (1) she is a qualified person with disabilities, as defined in the ADA, (2) the State has determined that community based treatment is appropriate and (3) she does not oppose living in the community. At that point, the burden then shifts to the State to prove that providing the accommodation would require a "fundamental alteration" in the nature of its programs. *Olmstead*, 527 U.S. at 603 and 604. The State has not met its burden.

There can be no question that Appellant has clearly presented a *prima facie* case demonstrating that she is a disabled person, that the State has determined that her receiving services in the community is appropriate and that she does not oppose receiving services in the community - indeed that is her clear choice. The State has totally failed to meet its burden of

proving that providing Appellant with an oximeter cable would fundamentally alter the State's programs and that providing this equipment would be inequitable "given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons" who are disabled.

In discussing the meaning of "fundamental alteration," the plurality in *Olmstead* instructed the States that:

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

Id. at 604. One way that the State may meet its burden by demonstrating that it has made reasonable modifications to its programs is to demonstrate that it has a comprehensive or effectively working plan to provide services in less restrictive settings:

If, for example, the State were to demonstrate that it had *a comprehensive, effectively working plan* for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.

Id. at 605-606 (emphasis added). But, unlike most states, South Carolina does not have a comprehensive or effectively working *Olmstead* plan.

Not only has the State failed to prove that providing the oximeter cable would cause a fundamental alteration in its programs, it is obvious from the protracted litigation in this case in which the State has denied Appellant's simple request for a fair hearing that State taxpayers have spent far more money defending an indefensible position than they would have spent paying for the needed device. As Judge Baxley found in *T.R. v. South Carolina Department of Corrections*:

We are now eight years into this litigation.³ Rather than accept the obvious at some point and come forward in a meaningful way to try and improve its mental health system, Defendants have fought this case tooth and nail - on the facts, on the law, on the constitutional issues, portraying itself as beleaguered by the burdensomeness of the Plaintiff's discovery, and generally harrumphed by the invasive nature of Plaintiff's counsel's tactics and strategies.

...

The hundreds of thousands of tax dollars spent defending this lawsuit, at trial, and most likely now on appeal, would be better expended to improve the mental health services delivery at SCDC.

Case No. 2005-CP-2925 at 45, Richland County Court of Common Pleas, January 8, 2014.

Exhibit 4.

The same obstructionist tactics exhibited by the State's attorneys in *T.R.* have been used by Executive Branch state agencies in Appellant's case to keep her from receiving a simple device that she needs to measure her oxygen supply. 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). That court reported that: "According to expert medical testimony presented at trial using a proper pulse oximeter could have saved Mr. Jackson's life." *Id.* at fn 8.

It is not inconsequential that as a condition of receiving 70% matching federal funding to operate the Medicaid program in South Carolina, DHHS has assured the federal government that it will provide necessary safeguards to protect the health and welfare of Medicaid waiver participants like Appellant. 42 C.F.R. 441.464. The failure to provide this device and the patterns and practices complained of in Appellant's 2013 complaint (*R.* at 6 and 13) has squarely

³ Appellant's appeal entering into its eighth year, having been filed in 2007.

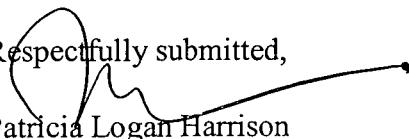
placed her at risk of institutionalization. *Peter B. v. Sanford*, Case No. 6:10-cv-00767, Report and Recommendation, November 24, 2011.

Appellant requests an order finding that Respondent is in violation of the Americans with Disabilities Act by failing to prove that providing the requested cable is not a reasonable accommodation and that it would fundamentally alter the State's programs for DHHS to provide the cable, that Appellant is the prevailing party on this issue, that Respondent was not substantially justified in denying payment for this device and that she is entitled to an award of legal fees pursuant to S.C. Code 15-77-300.

VI. Conclusions

However complicated and convoluted other provisions of the Medicaid Act may be, federal law is quite clear and unambiguous that an evidentiary hearing must be granted to any participant who requests one. Appellant has shown that her statutory and constitutional rights to due process have been violated. In addition to demonstrating other violations of the Medicaid Act described herein, Respondent has failed to prove that paying for the oximeter cable would fundamentally alter the State's programs and Appellant is entitled to an order finding that Respondent has violated the Americans with Disabilities Act. Appellant requests an order granting the relief requested in his Brief. Appellant prays for an order finding that she is the prevailing party, that the State was not substantially justified in failing to provide the oximeter cable and that she is entitled to legal fees pursuant to S.C. Code 15-77-300, along with instructions for claiming those fees.

Respectfully submitted,


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May 28, 2014

List of Exhibits

1. November 21, 2014 Order of DHHS hearing officer in Waddle v. DHHS
2. December 23, 2014 Order of DHHS hearing officer in Waddle v. DHHS
3. 2013 Order of DHHS hearing officer dismissing appeal in Brown v. DHHS
4. *TR v. S.C. Department of Corrections*, Case No. 2005-CP-2925 at 45, Richland County Court of Common Pleas, January 8, 2014.

Exhibit 1

B.W. v. SCDHHS: Final Administrative Order, November 19, 2013

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. Zimring*, 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

ordered by her treating physician at the time of her discharge from the hospital (28 hours per week of RN and 84 hours per week of LPN) should have continued throughout this matter. The Respondent violated the Petitioner's due process rights in enforcing its waiver reductions against her during the pending appeal. Because of the due process violations, it is unnecessary to determine whether the Respondent has given agency rules the weight of a promulgated regulation when the reductions were applied to her.

2. While under the age of 21, the Petitioner was entitled to the protections afforded by EPSDT including deference to the orders of her treating physicians regarding medically necessary services while recognizing that the Respondent can impose reasonable limits on the treating physicians' orders. There has been no testimony by the Petitioner's physician that has been subject to cross examination. However, the initial order of the treating physician was issued during the Petitioner's lengthy hospital stay and was supported by a treating physician's order two years later. The Petitioner offered into evidence contemporaneous orders and affidavits from her treating physicians stating that 28 hours per week of RN services were medically necessary. The testimony provided by the Respondent's Medical Director showed a lack of first-hand knowledge of the Petitioner's medical needs. The recommendations of the Respondent's physician were based on the Petitioner receiving about 50 hours of nursing care per week (an amount which she has not received since 2008) along with the assumption that both parents were providing supporting care to the Petitioner. The Respondent has not provided any record of a medical examination of the Petitioner's needs 30 days after her discharge from the hospital. Nor did the Respondent provide any record of a medical examination at the 2009 or the 2012 hearings. It appears as though the Respondent has not conducted a

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.

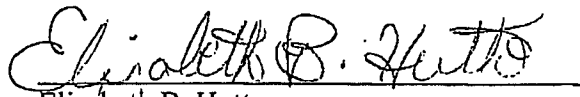
DECISION

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

Exhibit 2

B.W. v. SCDHHS: Order - Respondent's Motion for Reconsideration,
December 23, 2013

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

Exhibit 3

Order of Dismissal in the Appeal Matter of P.B. v. SCDHHS,
March 12, 2013

**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

Exhibit 4

T.R., et al v. SCDC: Order Granting Judgment in Favor of
Plaintiffs, January 8, 2014

STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

T.R., P.R., and K.W., on behalf of
themselves and others similarly situated;
and Protection and Advocacy for People
with Disabilities, Inc.,

Plaintiffs,

v.

South Carolina Department of Corrections
and William R. Byars, Jr., as Agency
Director of the South Carolina Department
of Corrections

Defendants.

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT

C/A No.: 2005-CP-40-2925

**ORDER GRANTING JUDGMENT IN
FAVOR OF PLAINTIFFS**

2014 JAN -8 PM 12:36
CLERK OF COURT
C.C.P. & G.S.

It has been the privilege of this writer to serve the State of South Carolina as a general jurisdiction judge for fourteen years. At the time this case was heard, Court Administration reported there were more than 5,000 new case filings per year for each of our state's circuit court judges. Thus, over 70,000 cases of every imaginable sort have come to this Court over the years. This case, far above all others, is the most troubling.

This case is a class action brought on behalf of approximately 3,500 state inmates who meet the definition of being seriously mentally ill. For purposes of this suit, the term "serious mental illness" was specifically defined in the Class Certification order dated November 1, 2007, and may be succinctly stated as all SCDC inmates from the date of the filing of the complaint who have been hospitalized for psychiatric services, referred to an Intermediate Mental Health Care Services Unit, or diagnosed by a psychiatrist with the following mental illness: Schizophrenia, Schizoaffective Disorder, Cognitive Disorder, Paranoia, Major Depression, Bipolar Disorder, Psychotic Disorder, or any other mental condition that results in significant

functional impairment including inability to perform activities of daily living, extreme impairment of coping skills, or behaviors that are bizarre and/or dangerous to self or others. Plaintiffs claim that their treatment within SCDC, or lack of treatment, constitutes a violation of the state constitution.

The evidence in this case has proved that inmates have died in the South Carolina Department of Corrections for lack of basic mental health care, and hundreds more remain substantially at risk for serious physical injury, mental decompensation, and profound, permanent mental illness. As a society, and as citizen jurors and judges make decisions that send people to prison, we have the reasonable expectation that those in prison – even though it is prison – will have their basic health needs met by the state that imprisons them. And this includes mental health. The evidence in this case has shown that expectation to be misplaced in many instances.

 Economic downturn and financial pressures have brought great change to our country. One of these is that the various state departments of corrections are now more than ever the collection place of the seriously mentally ill among the citizenry. The incidence of serious mental illness within the general population is less than four (4%) percent¹. In the typical Department of Corrections, it is between 15 and 20 percent. In South Carolina, the evidence in this case shows it to be approximately 17 percent, in spite of the Department's claim that it is 12.9 percent. If 17 percent of the prison population had advanced cancer and there was inadequate and in some cases nonexistent treatment for cancer in prison, the public would be outraged. Yet this is the case for serious mental illness.

¹ Figures vary depending upon the source, demographics, and differences in various definitions of "serious mental illness." The Court takes judicial notice of the statistical findings of the National Institute of Mental Health, which places the general population figure at 3.9%. Further statistical information may be obtained from the NIH at www.nimh.nih.gov/statistics/SMI_AASR.shtml.

This litigation does not occur in a vacuum. What happens at the Department of Corrections impacts all of us, whether it is from the discharge of untreated seriously mentally ill individuals from prison into the general population, or tremendously increased costs for treatment and care that might have been prevented, or the needless increase in human suffering when use of force replaces medical care. The decisions of our Courts reflect the values of our society. To that end, our state can no longer tolerate a mental health system at the South Carolina Department of Corrections that has broken down due to lack of finances and focus.

While the Court finds the inadequacy of the mental health system at SCDC has not occurred by design, but instead by default, the Court further finds this decision in favor of Plaintiffs should not come as a shock to SCDC. Previous internal and external reviews of the SCDC mental health system have found multiple inadequacies and failures. Despite its knowledge of the grave risks these deficiencies pose to mentally ill inmates, SCDC has failed through the years to take reasonable steps to abate those risks. The Court recognizes that the Department is underfunded and understaffed in many particulars, not just mental health services delivery. The operation of any state agency is a matter of competing priorities, and the General Assembly, as keeper of the public purse, is not in a position to excessively fund any entity. Thus, this decision will ultimately require an increase in priority for mental health services commensurate with the level of serious mental illness within the prison population.

DECISION

In its prior Order Setting Forth Applicable Constitutional Standards (“Standards Order”), the Court delineated the standard of liability and burden of proof applicable to Plaintiffs’ constitutional claim under Article I, § 15 of the South Carolina Constitution, which prohibits “cruel and unusual punishment.” To prevail on a claim under Article I, § 15, the Court stated

that Plaintiffs must prove that Defendants acted with “deliberate indifference to serious medical needs of prisoners.” Standards Order at 3 (quoting *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). This deliberate indifference standard contains both an objective and subjective component. See *Farmer v. Brennan*, 511 U.S. 825, 834-37 (1994). To satisfy the objective component, Plaintiffs must demonstrate that they are subjected to a substantial risk of harm that is sufficiently serious. *Id.* The objective component is not limited to past harm, but also protects inmates from an unreasonable risk of future harm. *Helling v. McKinney*, 509 U.S. 25, 35 (1993). Plaintiffs may satisfy the objective component by showing that systemic deficiencies in a prison mental health system expose inmates with serious mental illness to a substantial risk of serious future harm. Standards Order at 7-8, citing *Helling*; 509 U.S. at 35; *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983); *Flynn v. Doyle*, 2009 WL 4262746 at *19 (E.D. Wis. 2009); *Madrid v. Gomez*, 889 F. Supp. 1146, 1256 (N.D. Cal. 1995); *Neiberger v. Hawkins*, 208 F.R.D. 301, 317 (D. Colo. 2002).

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The Court noted the need for guideposts in determining whether Plaintiffs satisfied the objective component of the deliberate indifference standard. Accordingly, within this legal framework, the Court identified and articulated six factors that would serve as benchmarks for determining whether SCDC’s mental health program exposed mentally ill inmates to a substantial risk of serious harm. Stated succinctly, the evidence at trial should establish whether the SCDC mental health services system contained the following adequately functional components:

1. A systematic program for screening and evaluating inmates to identify those in need of mental health care;
2. A treatment program that involves more than segregation and close supervision of mentally ill inmates;

3. Employment of a sufficient number of trained mental health professionals;
4. Maintenance of accurate, complete, and confidential mental health treatment records;
5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation; and
6. A basic program to identify, treat, and supervise inmates at risk for suicide.

Standards Order at 8-10, *citing Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.C. Tex. 1980) *aff'd in part, rev'd in part*, 679 F.2d 1115 (5th Cir. 1982), *amended in part, vacated in part*, 688 F.2d 266 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983).

Employing these factors in the context of the objective component of the deliberate indifference standard, the Court finds by a preponderance of the evidence that the Plaintiffs have met the burden of proof and makes the following threshold findings.

 First, the mental health program at SCDC is severely understaffed, particularly with respect to mental health professionals, to such a degree as to impede the proper administration of mental health services. This deficiency has a substantial impact on every aspect of the mental health program, beginning at Reception and Evaluation ("R&E"), where inmates are screened and evaluated for mental health needs, continuing into the treatment programs for seriously mentally ill inmates, and ending with deficient discharge planning for seriously mentally ill inmates being returned to the general public.

Second, seriously mentally ill inmates are exposed to a disproportionate use of force and segregation (solitary confinement) when compared with non-mentally ill inmates. Segregation and use of force are often used in lieu of treatment, with severe consequences for inmates with

serious mental illness. The inappropriate and extended reliance on segregation to manage inmates with serious mental illness, particularly those in crisis, exposes them to a substantial risk of serious harm by limiting their access to mental health counselors and psychiatrists, disturbing their eating and sleeping cycles, disrupting the administration of medications, and deepening their mental illnesses. These conditions have contributed to the deaths of multiple inmates in segregation, while placing other inmates and staff at risk. They have also led to the stigmatization of mental illness within SCDC that discourages inmates from seeking the limited mental health care the agency does provide.

Third, mental health services at SCDC lack a sufficiently systematic program that maintains accurate and complete treatment records to chart overall treatment, progress, or regression of inmates with serious mental illness.

Fourth, SCDC's screening and evaluation process is ineffective in identifying inmates with serious mental illness and in providing those it does identify with timely treatment.

Fifth, SCDC's administration of psychotropic medications is inadequately supervised and evaluated.

Sixth, SCDC's current policies and practices concerning suicide prevention and crisis intervention² are inadequate and have resulted in the unnecessary loss of life among seriously mentally ill inmates.

As a result of the above findings, the Court further finds that SCDC's mental health system exposes seriously mentally ill inmates to a substantial risk of serious harm and Plaintiffs have therefore satisfied the objective component of the deliberate indifference standard.

² "Crisis intervention" refers to SCDC's response to an actively mentally ill inmate who poses an immediate danger and must be sequestered for his own protection or the protection of other inmates and correctional officers.

The subjective component is met by proof that a defendant “knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it.” *Farmer*, 511 U.S. at 834-837. At trial, the Plaintiffs presented overwhelming evidence that SCDC has known for years that its policies and practices expose seriously mentally ill inmates to a substantial risk of serious harm but has failed to take reasonable measures to abate that risk. The Court finds, therefore, that the Plaintiffs have satisfied the subjective component of the deliberate indifference standard.

As a result of the above findings, the Court grants judgment in favor of the Plaintiffs.

Below, the Court has separated the remainder of this Final Order into two sections. The first section articulates the factual findings and conclusions underlying the Court’s decision with respect to the objective component by examining each of the six *Ruiz* factors listed above. The first section then articulates the factual findings and conclusions related to the subjective component. The findings made therein are by a preponderance of the evidence. Section Two then addresses the remedy the Court will grant in this case and the mechanism used to achieve it.

With regard to the factual findings and conclusions mentioned below in Section One, there are several references to individual circumstances involving specific inmates. The Department argued at trial that reference to an individual inmate and his/her particular situation was anecdotal and not indicative of the general administration of mental health services. Moreover, counsel for SCDC essentially argued that some of the specific inmate situations were “outliers” in that such was a constellation of unique events and circumstances that brought about an unfortunate result. The Court specifically rejects that argument. While no system involving thousands of inmates is expected to be perfect, the Court finds that the individual circumstances

referred to below are the result of a system that is inherently flawed in many respects, understaffed, underfunded, and inadequate.

I. FACTUAL FINDINGS/DISCUSSION

A. Objective Component

1. A systematic program for screening and evaluating inmates to identify those in need of medical care

As of 2011, 12-13 percent of the SCDC inmate population had been diagnosed by SCDC with a mental illness and was on the Department's mental health caseload. From that data, with a total inmate population at the time of trial of 23,306, a 12.9 percent fraction yields an approximate figure of 3,006 inmates that have been diagnosed as mentally ill.³ Based on universally accepted national statistics, evidence presented to the Court at trial strongly indicates this percentage should be much higher. Multiple studies conducted nationwide suggest that a more accurate percentage of inmates with a serious mental illness should be somewhere in the range of 15 to 20 percent. SCDC's expert, Dr. Scott Haas, testified that seriously mentally ill inmates ordinarily comprise 18 percent of a prison population. Plaintiffs' expert, Dr. Raymond F. Patterson, testified that after detailed analysis, 17 percent was a conservative estimate of SCDC's seriously mentally ill population, and the Court finds the basis of his analysis to be credible.

The Court further finds this low, acknowledged percentage of mentally ill inmates at SCDC troubling because it indicates a high likelihood that there are hundreds of inmates with a serious mental illness at SCDC who are not receiving any treatment due to deficiencies in the screening and evaluation process used to identify and classify those with a serious mental illness.

³ Exact numbers fluctuate due to the constant intake and release of inmates.

This low identification of mentally ill inmates has a synergistic impact on the mentally ill population, as it leads to a reduction in mental health professionals, the further disproportionate cutting of costs in difficult economic times within the mental health system because of a perceived lack of need for services, and a skewed analysis as to the efficacy of the existing mental health system. R&E serves as the intake facility for inmates entering into SCDC. If inmates with mental illnesses are not identified and appropriately classified at R&E, the Court finds that these inmates face a substantial risk of serious harm.

In addition to the concerns mentioned above, there was also evidence presented to the Court of regular violations of the SCDC mental health policy, two of which are particularly relevant to the Court as they relate to the screening and evaluation process at R&E. First, SCDC policy requires that a mental health counselor must meet with an inmate within 48 hours of the inmate being assigned to that counselor's caseload. At trial, there was evidence submitted to the Court of regular and persistent violations of this policy. Second, inmates are not being seen by a psychiatrist within thirty days of the counselor's initial assessment when a need for psychiatric treatment is indicated, also a violation of SCDC policy. Consequently, this results in inmates who are referred to a psychiatrist at R&E, but are then transferred into SCDC general population prior to assessment by that psychiatrist, creating a risk of harm for all inmates.

The Court finds, due to the concerns listed above, that the program used by SCDC for screening and evaluation fails to adequately identify and classify those inmates suffering from serious mental illness, thereby exposing them to a substantial risk of serious harm.

2. A treatment program that involves more than segregation and close supervision of mentally ill inmates

a. Segregation

The treatment program at SCDC places heavy reliance on segregation and use of physical force against seriously mentally ill inmates, as opposed to treatment.

Mentally ill inmates are substantially overrepresented in segregation units, known as Special Management Units ("SMU"), within SCDC. Inmates in segregation stay in solitary confinement in their cells 23-24 hours a day. Visitation, telephone, and other privileges are significantly restricted. As of September 2011, the percentage of mentally ill inmates in SMUs at the three SCDC institutions where the majority of men with serious mental illness are assigned ("Area Mental Health Institutions") demonstrates the disproportionate use of segregation to which members of the Plaintiff class are subjected. At Lee Correctional Institution ("Lee"), 16 percent of the total inmate population was mentally ill, yet 27 percent of its inmates in SMU were mentally ill.⁴ The corresponding numbers at Perry Correctional Institution ("Perry") were 24 percent and 40 percent. At Lieber Correctional Institution ("Lieber"), the differential was even greater, where mentally ill inmates comprised 20 percent of all inmates, yet 42 percent of the inmates that were in segregation. During this same period, the percentage of mentally ill inmates in SMUs in all SCDC institutions was 23 percent, even though they represented less than 13 percent of the total inmate population.

Taking the entire population into consideration, a mentally ill inmate is twice as likely to be placed in segregation as a non-mentally ill inmate. As of September 2011, 16 percent of inmates on the mental health caseload were in SMUs in contrast with 8 percent of non-mentally ill inmates. For security detention, the most restrictive form of segregation, where inmates are placed in solitary confinement for indefinite periods, mentally ill inmates are more than three

⁴ These percentages are based on the SCDC mental health caseload.

times more likely to be assigned this status than other inmates, at a rate of 8.7 percent compared with 2.8 percent.⁵

Not only are mentally ill inmates overrepresented in SMUs, they also spend disproportionately longer periods of time in the SMUs. For many mentally ill inmates, this period of isolation in SMU has lasted for several years. For example, the average cumulative disciplinary detention sentence for inmates with mental illness as of January 13, 2012 was 647 days, compared to 383 days for non-mentally ill inmates. These averages include extremely long periods of segregation for inmates whose disciplinary detention sentences exceeded their projected release date from SCDC. Again, these extended sentences were meted out against mentally ill inmates at over twice the rate of other inmates. The lengths of these sentences in segregation were also far greater for members of the Plaintiff class, exceeding their projected release date on average by 1,968 days or 5.39 years, compared with 1,065 days or 2.92 years for other inmates. Of the ten longest periods of disciplinary detention sentences beyond projected release dates, nine of the inmates were mentally ill. Their cumulative sentences for solitary confinement ranged from 20-36 years.

The evidence showed that these extended periods of segregation too often reflect the accumulation of disciplinary detention sentences for non-assaultive behavior of mentally ill inmates. For example, one 51-year-old mentally ill inmate who had been hospitalized at SCDC's psychiatric facility accumulated 19 years of disciplinary detention sentences from 2005-2008. For one non-assaultive offense in which he threatened harm, he received 999 days of disciplinary detention and lost visitation for three years. In interviews with Plaintiffs' experts, he was

⁵ The two principal forms of punitive segregation are security detention and disciplinary detention. Disciplinary detention consists of sentences served in segregation for a specific period of time for violation of SCDC administrative rules. Security detention is a classification assigned to inmates determined to present a particular risk to other inmates or staff that often remains in effect for periods lasting several years.

distressed that he was being denied “400 million dollars in his bank” and was set to appear on the television program “The Rich and Famous.”

A 27-year-old female mentally ill inmate accumulated six and a half years of disciplinary detention segregation and lost access to the telephone and visitation for eight years for non-assaultive offenses, most of which were verbal or profane threats to staff or other inmates. One of the charges was prompted when she threatened two inmates who were making derogatory remarks about a medical condition that required her to wear diapers.

The evidence revealed that the great majority of the extreme periods in segregation are in fact served. For example, Leslie Cox, a member of the Plaintiff class, was confined in SMU for at least 2,565 consecutive days, from February 2001 - February 2008. James Wilson, another mentally ill inmate, was confined in SMU for at least 2,491 consecutive days.⁶ SCDC records provide conflicting information about mentally ill inmate Rowland Dowling, who spent either 1,777 or 2,200 consecutive days in solitary. Other mentally ill inmates were confined in solitary for similarly lengthy periods.

SCDC's Guilty But Not Accountable (“GBNA”) policy should theoretically reduce the number of mentally ill inmates in segregation but, in fact, has had a negligible effect. SCDC counselors are responsible for recommending findings of GBNA but this Court finds that, as Dr. Patterson testified, many SCDC counselors are not qualified to analyze accountability. Only 2 percent of mentally ill inmates receiving segregation sentences are determined to meet GBNA criteria.⁷ Moreover, of those found to be GBNA, the finding has had no effect on their

⁶ SCDC records indicate that inmates Cox and Wilson were still in segregation as of February 25, 2008. It is unknown how much longer they remained in segregation after that date.

⁷ Evidence introduced by Plaintiffs also showed that a small percentage of the disciplinary detention sentences for male mentally ill inmates at Area Mental Health Institutions were reduced or waived during a 21-month review period between 2010 and 2011.

sentences. Of all inmates in SCDC custody on September 1, 2011 who had been found GBNA, 25 were mentally ill. Despite being found “not accountable,” all 25 had been sentenced to segregation.

The American Correctional Association (“ACA”) defines disciplinary detention or punitive segregation as follows:

A form of separation from the general population in which inmates committing serious violations of conduct regulations are confined by the disciplinary committee or other authorized group for *short periods of time* to individual cells separated from the general population.

ACA Standards for Adult Correctional Institutions Supplement, p. 306 (2008) (emphasis added).

The ACA standards also recognize the potentially harmful effects of punitive segregation on the mental health of any inmate:

Inmates whose movements are restricted in segregation units may develop symptoms of acute anxiety or other mental health problems; regular psychological assessment is necessary to ensure the mental health of any inmate confined in such a unit beyond 30 days.

ACA Standards for Adult Correctional Institutions, 3rd Edition, Standard 3-4244 (2008).

Job 13
The evidence presented by Plaintiffs demonstrates that SCDC consistently showed little to no regard for the mental health of inmates in imposing periods of disciplinary or security detention, in the lengths of the segregation imposed, or in the effects on mentally ill inmates. The Department’s practice consistently violates the ACA standards. Neither the disciplinary detention sentences nor classifications in security detention are for short periods of time. Once in segregation, the level of therapeutic care or intervention to address the needs of mentally ill inmates is grossly inadequate.

Dr. Janet Woolery, the principal psychiatrist at Lee, estimated that approximately 40-50 percent of the Lee SMU inmates she saw were demonstrating active psychotic symptoms.

Rather than placing mentally ill inmates into treatment programs, it appears that they are merely placed in SMUs. SMU patients receive no group therapy and sessions with both psychiatrists and mental health counselors are seldom held in a confidential setting. Sixty-three percent of the counselor audits produced by SCDC noted deficiencies for untimely psychiatric sessions and 77 percent noted deficiencies for untimely counselor assessments. Patient medical records provide further evidence that SMU patients often do not see psychiatrists or counselors on a timely basis. For example, SCDC policy requires that Edward Barton, diagnosed with schizophrenia and classified as an Area Mental Health patient, be seen by a mental health counselor at least once every 30 days, as well as by a psychiatrist at least once every 90 days. Yet, from July 2008 – November 2010, while confined in an SMU, Barton on six occasions went over 30 days without seeing a counselor; on four of those occasions he went over 60 days without seeing a counselor; and once he went 9 months without seeing a counselor. From September 2010 – August 2011, Barton twice went over 120 days without seeing a psychiatrist and once went over 6 months.

9-14
SCDC's heavy reliance on segregation of mentally ill inmates raises serious concerns for the Court. As acknowledged by SCDC Mental Health Regional Coordinator Jacqueline Strong, risk factors for psychosis and suicide increase while an inmate is in SMU. It is not uncommon for an inmate in SMU to develop depression and experience a disturbance in eating and sleeping cycles.⁸

⁸ Defendants relied upon a Colorado Department of Corrections study to assert that long-term segregation has no significant detrimental effect on mental health. However, the Court finds that the Colorado study is distinguishable from the situation at SCDC for two reasons. First, the Colorado study was limited to inmates who had spent no more than twelve consecutive months in segregation. Many SCDC mentally ill inmates stay in segregation for much longer periods of time. Second, the Colorado study was expressly limited to SMUs with substantially similar conditions to the Colorado State Penitentiary. Plaintiffs' two psychiatric experts, Dr. Metzner and Dr. Patterson, each testified they were familiar with the Colorado State Penitentiary and that conditions in SCDC segregation units were much harsher. As Dr. Patterson testified, the difference was like "night and day."

Moreover, evidence in the case shows conditions in SMUs fall below what is acceptable for a 21st century correctional institution. SMU cells are both extremely cold and inordinately filthy, often with the blood and feces of previous occupants smeared on the floor and walls.

Within the SMU of Lee Correctional Institution is a special 8-cell unit known as "Lee Supermax." On February 7, 2008, inmate Jerome Laudman was transferred to a cell in Lee Supermax. Laudman was schizophrenic, intellectually disabled, and had a speech impediment. According to his mental health counselor, he was neither aggressive nor threatening. No one notified the counselor of Laudman's transfer to Lee Supermax. According to an internal SCDC investigative report, Laudman was sprayed with chemical munitions and physically abused by a correctional officer during the transfer to Lee Supermax. The move was videotaped pursuant to policy, but when viewed by the SCDC investigator, the tape was, inexplicably, mostly blank. Laudman was stripped naked and left in a completely empty Supermax cell.

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On February 11, a correctional officer observed that Laudman was sick and weak but did not report it. At some point after February 11, Laudman stopped eating and taking medication. On the morning of February 18, a correctional officer saw Laudman lying on the cell floor in feces and vomit. He lay there "all morning," according to the SCDC investigative report. At approximately 1:30 or 2:00 p.m., two nurses were called. They reported that, in addition to feces and vomit, 15-20 trays of rotting, molding food were in the cell. Both the nurses and the correctional officers refused to retrieve the body. After a further delay, two inmates came to retrieve Laudman, who was unconscious but alive. Later that afternoon, however, he died in a local hospital ER of a heart attack. The hospital report noted the presence of hypothermia. The SCDC investigator found evidence of an attempted cover-up by correctional officers who cleaned Laudman's cell before photographs could be taken. Even after the cleaning, the

photographs taken by the investigator show the cell in a deplorably dirty state. After Laudman's death, SCDC did no quality improvement reviews of Lee Supermax procedures and practices. In September 2008, seven months after Laudman's death, Dr. Metzner and Dr. Patterson inspected Lee Supermax and described it as "filthy."

b. Use of force

Mentally ill inmates also suffer from disproportionate, unnecessary, and excessive uses of force.

i. Disproportionate Use of Force. Between January 2008 and September 2011, mentally ill inmates were subjected to uses of force at a rate two and half times greater than non-mentally ill inmates. During this period, 27 percent of the Plaintiff class was subjected to the use of force in contrast to only 11 percent of other inmates. At the Area Mental Health Institutions for men, the reliance on use of force was even greater. At Lee, Lieber, and Perry, 40 percent, 43 percent, and 44 percent of mentally ill inmates were subjected to force, respectively, while the corresponding numbers of non-mentally ill inmates subjected to force at these institutions were 23 percent, 21 percent, and 16 percent, respectively. Although force was applied far less frequently at Camille G. Graham Correctional Institution ("Graham"), the Area Mental Health Institution for women, the same pattern was present. During the relevant review period, only fourteen use-of-force incidents were reported; however, ten of these incidents were directed toward mentally ill women, even though members of the Plaintiff class constituted less than half of the total inmates at Graham.

The evidence was clear and compelling that SCDC resorts to use of force in the agency's attempt to manage the conduct of mentally ill inmates. Of the inmates who were subjected to use of force, each mentally ill inmate who had been the object of a reported use of force during this

period was subjected on average to 3.35 separate incidents, while the use-of-force rate for other inmates was almost half that, at 1.72 incidents per inmate.

Of the thirty inmates most frequently subjected to the use of force, twenty-six were on the mental health caseload. The mental health conditions were so serious for many of these individuals that fifteen of the twenty-six required hospitalization during the same period at Gilliam Psychiatric Hospital ("Gilliam" or "GPH"). Ten of these fifteen inmates were hospitalized on multiple occasions. James Howard was subjected to 81 separate use-of-force incidents. Mr. Howard was hospitalized for psychiatric treatment on five separate occasions during this same period between January 2008 and September 2011.

SCDC's overreliance on the use of force in attempting to manage mentally ill inmates is, in part, a direct effect of the lack of training correctional officers receive. SCDC training coordinator Yolanda Delgado testified in deposition only twelve days before trial that "less than a handful" of correctional officers attended training sessions intended to improve the staff's knowledge and skills in dealing with mentally ill inmates.

ii. Unnecessary and Excessive Use of Force. Plaintiffs' corrections expert, Steve J. Martin, testified that while SCDC's use-of-force policy was consistent with national correctional standards, its use-of-force practices were not. Based on his review of over 1,000 incident reports at SCDC involving OC spray (pepper spray), Mr. Martin testified a pattern and practice existed that violated national standards and SCDC's own use-of-force policy. First, Mr. Martin testified in detail about eighteen case examples at SCDC of the unnecessary use of force where no threat of harm or other urgent circumstances were present and, in some cases, where OC spray was used simply as punishment. Mr. Martin testified, and the Court finds, that these cases were representative of the more than 1,000 incidents he

reviewed. Second, Mr. Martin found it common for SCDC correctional officers to use excessive force. For example, contrary to SCDC policy, SCDC officers routinely gas inmates with OC spray in amounts that exceed manufacturer instructions and at closer distances than the manufacturer directs. Mr. Martin identified nine case examples, documented in SCDC reports, where SCDC officers had used MK-9 crowd control fogger devices in large disbursements in individual closed cells, again contrary to manufacturer instructions and SCDC policy. In fact, Mr. Martin testified that having reviewed thousands of uses of OC spray in prisons and jails throughout the country, he had “never seen MK-9, a crowd control contaminant, so frequently used by a correctional force inappropriately.” The use of such force is without penalogical justification.

SCDC’s unnecessary and excessive use of OC spray on mentally ill inmates is consistent with its unnecessary and excessive use of physical restraints. Contrary to its policy and national correctional standards, SCDC places inmates in restraint chairs for predetermined blocks of time in set, four-hour increments.⁹ For example, on December 12, 2007, inmate Steven Patterson was transferred to Perry from Gilliam but, by SCDC’s mistake, with only five days’ worth of psychotropic medications. On January 2, 2008, Patterson’s medical record noted that he had not received medication since December 17, 2007 “and he’s not doing well.” That same day, he cut himself with a plastic spoon and was placed naked in a restraint chair for twelve hours, even though the videotape of his time in the chair shows him calm and cooperative. On January 3, he was returned to Gilliam.

⁹ SCDC witnesses testified this practice was changed shortly before the start of this trial so that inmates no longer will be placed in restraint chairs for predetermined blocks of time. The timing of this change concerns the Court, however, for “practices may be reinstated as swiftly as they were suspended.” *Thomas v. Bryant*, 614 F.3d 1288, 1320 (11th Cir. 2010).

Mr. Martin both by Perry correctional officers and inmates. Inmates Richard Patterson and Jonathan Roe both testified about spending hours in what they characterized as the "Jesus" position.

OC spray and restraint chairs are not the only methods of physical force employed by SCDC against mentally ill inmates. Shawn Wiles, a mentally ill inmate in SCDC's Maximum Security Unit, testified that correctional officers restrained his arms in a twisted position, soaked him with water, and left him outside for approximately an hour on a cold December night.

While SCDC contends these are isolated examples of inappropriate conduct by correctional officers, it offered little or no evidence of effective supervisory oversight of the use of force. Mr. Martin testified that one of the standard protections prison systems use to guard against excessive use of force is review of use-of-force incidents. The first element of an effective review process is an examination of the cases that are referred to senior management for review of questionable uses of force. The second element consists of an assessment of the findings concerning allegations of inappropriate force and corrective actions taken. Of the more than one thousand cases Mr. Martin reviewed, very few were referred to senior SCDC officials to assess an alleged inappropriate use of force. Mr. Martin found that of the few cases that were referred, SCDC officials made virtually no findings of excessive or unnecessary force.

In a prison system of more than 23,000 inmates, Mr. Martin testified that the almost complete absence of the identification by managers of inappropriate uses of force is a "huge red flag" that raises serious questions about the existence of an effective system to manage the use of force by correctional officers. Mr. Martin testified that the risk of harm to mentally ill inmates from the unnecessary and excessive use of force, if left unattended and not corrected, is ongoing

and substantial. The Court finds Mr. Martin's testimony, and the bases for his opinions, to be credible.

The Court is concerned by the absence of referrals for investigation of the cases presented by Mr. Martin, and the absence of findings by senior SCDC managers that those cases raise serious questions about the application of force against mentally ill inmates. The Court finds that such excessive uses of force have been largely unreported, uninvestigated, and unmanaged. The Court further finds that Plaintiffs have proven a pattern and practice of the use of unnecessary and excessive force.

c. Limited involvement of psychiatrists

A substantial contributing factor to the lack of an effective treatment program is the limited involvement of psychiatrists in creating and administering treatment plans for mentally ill inmates. Psychiatrists at SCDC have no administrative or policy-making duties, and there is evidence that they do not attend meetings to create and develop treatment plans for inmates. The Court finds that psychiatrists, as the lead mental health professionals in the mental health program, must be more directly involved in creating and developing treatment plans. Furthermore, deposition testimony of some psychiatrists reveals an alarming lack of knowledge of policies and procedures at SCDC, the levels of care and criteria for referral to a particular level of care, and the role of the counselor in the mental illness treatment process. For example, SCDC psychiatrist Dr. Poiletman did not know what the terms SMU and CI stood for – meaning Special Management Unit and Crisis Intervention – terms inextricably tied to mentally ill inmates at SCDC. He did not know the difference between Area Mental Health patients and outpatients, did not know what mental health counselors do, and had “no idea” who drafted treatment plans. Likewise, Dr. Crawford, the principal psychiatrist at Graham, could not

describe the distinction between an Intermediate Care Services patient and an Area Mental Health Patient. She did not review treatment plans and did not start attending treatment team meetings until after her deposition. Dr. Woolery, the principal psychiatrist at Lee, was unfamiliar with treatment plans, did not know whether any of her patients were in Lee Supermax, and had never seen Lee Supermax herself. The Court finds these examples both illuminating and disturbing. For psychiatrists and other mental health staff at SCDC to provide effective services, they must have a more intimate knowledge of the processes and procedures vital to the mental health services system they are expected to direct.

d. Limited access to higher levels of care

Finally, SCDC's treatment program fails to provide mentally ill inmates with sufficient access to higher levels of care. All correctional mental health systems are organized by levels of care, and SCDC's system comprises four levels. From lowest to highest, these are outpatient, area, intermediate (ICS), and inpatient. The higher the level, the more services and staffing are required.

SCDC's Mental Health Director, Pamela Whitley, estimated that in 2008 the combined ICS and Area Mental Health caseload at SCDC was 515. In 2012, however, the combined ICS and area caseload was only 310, a 40 percent reduction. In February 2008, at Lee and Lieber combined there were 212 area and 211 outpatient mental health inmates, a 50/50 split. By September 2011, however, there were only 83 area inmates at Lee and Lieber (14.8 percent), while the outpatients numbered 478 (85.2 percent). From 2003 to 2011, male ICS inmates decreased from 315 to 135. The women's ICS program was discontinued, then revived, but at the time of trial consisted of only five inmates. In the 1990s Gilliam, the 88-bed inpatient psychiatric facility for male inmates, operated at full capacity, but at the time of trial only 47

beds were filled. It is undisputed that women inmates have a higher rate of mental illness than male inmates, but from 2007-2009 SCDC referred only 13 women to Geo Care (formerly "Just Care"), a private company with which SCDC contracts for inpatient psychiatric services for female inmates. SCDC offered no persuasive explanation for the decline in the number of inmates receiving higher levels of services during a period when the overall inmate population and mental health case load remained flat.

e. Conclusion

This Court finds that SCDC's use of force and segregation, as opposed to treatment, in a mental health system where psychiatrists have limited roles and where inmates face systemic obstacles in accessing higher levels of care, creates a substantial risk of serious harm for inmates with serious mental illness.

3. Employment of a sufficient number of trained mental health professionals

Job 23
The Court finds that the mental health program at SCDC is substantially understaffed. This has a causal effect for many insufficient aspects of the mental health program and greatly inhibits SCDC's ability to provide effective services to its mentally ill inmate population.

From 2008-2011, psychiatric staff at SCDC (psychiatrists and psychiatric nurse practitioners) ranged from 4.5 to 5.5 full-time equivalents (FTEs). At the time of this trial, SCDC had 5.5 FTE psychiatric staff serving an estimated 2,409 inmates on psychotropic medication, for a ratio of 1:437. If 17 percent of SCDC's population is mentally ill, rather than the 12.9 percent diagnosed by SCDC, the estimated number of inmates on psychotropic medication should be 3,170 and the ratio then is 1:575. Based on the testimony of Dr. Metzner and Dr. Patterson, the Court finds an appropriate ratio would be one FTE psychiatrist/psychiatric

nurse practitioner to every 150-200 inmates on psychotropic medication. At Gilliam, there are 1.2 FTE psychiatrists and psychiatric nurse practitioners for 62 patients, a 1:52 ratio. Based on the testimony of Plaintiffs' experts, the Court finds that an appropriate ratio for an inpatient setting would be 1:20. For the ICS program, there is currently .7 FTE psychiatric staff for 135 patients, a ratio of 1:193. Based on the testimony of Plaintiffs' experts, the Court finds that an appropriate ratio for intermediate care would be 1:150.

The Court also finds that SCDC is understaffed in clinical psychologists. In 2003, SCDC employed or retained four FTE clinical psychologists but needed, by its own admission, seven. From 2007-2011, however, SCDC averaged only .3 FTE psychologists.¹⁰ To add some context, SCDC's expert, Dr. Haas, testified that the Kentucky Department of Corrections, his former employer, had 15-16 FTE psychologists to serve a total population of 12,000 – 13,000 inmates, a ratio of approximately 1:800. By contrast, SCDC's .3 FTE psychologists serve a total population of approximately 23,000 inmates, a ratio of 1:69,697.

Jan 24
Likewise, the ratio for counselors at Area Mental Health Institutions as of January 2012 is also problematic: 1:72 at Lee; 1:84 at Perry, and 1:100 at Lieber. In response to this information, Dr. Patterson and Ms. Whitley, SCDC's Mental Health Director, agreed that a more appropriate ratio for counselors at the Area Mental Health Institutions is 1:40. Counselor staffing at outpatient prisons is also insufficient. Ms. Whitley testified she became "very concerned" when counselor-patient ratios at outpatient prisons exceeded 1:65, and Dr. Patterson agreed. SCDC data, however, shows that counselor ratios at most of its outpatient prisons exceed 1:65. At the time of trial, the counselor-patient ratio at McCormick Correctional Institution was 1:157 and at Turbeville Correctional Institution 1:183.

¹⁰ Shortly before trial, SCDC increased its psychologists to .7 FTE.

In total, Dr. Patterson recommended that SCDC employ at least an additional 20 FTE counselors, 14.5 FTE psychiatrists, and 17 FTE other types of mental health professionals. The Court accords great weight to Dr. Patterson's recommendations for staffing.

While it is clear that SCDC does not have enough counselors, it is equally clear that many of the counselors they do employ are unqualified. Hiring unqualified counselors can lead to the kind of deterioration in the delivery of mental health services that Perry experienced in 2009-2010. Within a period of a few months, all five of Perry's counselors were fired or resigned under investigation or following a serious reprimand. As Dr. Patterson testified, those counselor departures had a significant effect on mental health services provided at Perry, resulting in the cancellation of many psychiatric clinics and group therapy sessions. Disciplinary reprimands in counselor personnel files give further evidence of the overall poor quality of SCDC counselor services.

Sub 25
In 2009, SCDC began conducting internal audits of its mental health counselors. As Dr. Patterson and Dr. Metzner testified, the audits document a wide range of serious counselor deficiencies. Scores were particularly poor for Lee, Lieber, and Perry, the male Area Mental Health Institutions, where 55 percent of the audits were either "unsatisfactory" or "satisfactory, but with major concerns." Some of the deficiencies listed are disturbing. They include numerous instances of mentally ill inmates going for many months without seeing a counselor or psychiatrist, in violation of SCDC policy; treatment plans that were out of date and incomplete; and inadequate documentation of medication administration and group therapy sessions. Some counselors repeatedly failed their audits.

The Court finds that inadequate mental health staffing at all levels within SCDC represents a substantial risk of serious harm to inmates with serious mental illness.

4. Maintenance of accurate, complete, and confidential mental health treatment records

A treatment plan is intended to be a dynamic and fluid process that continues on a regularly scheduled basis, supplemented by constant updates and revisions. In order to be effective, treatment plans must be accurate, complete, readily accessible to professional staff, and confidential. During trial, evidence was presented to the Court indicating that documentation and maintenance of these records is poor. The treatment plans and automated medical records (“AMR”) do not clearly state problems, objectives, goals, or even identify plan-responsible staff.

The importance of maintaining accurate and complete treatment records is vital to any medical services delivery system. For mentally ill inmates in particular, treatment plans and AMRs are critical for assessing progress as well as the effect of medication and therapy.

In addition, Dr. Metzner offered several examples of basic information about its mental health program that SCDC’s aged computer system is unable to provide. For example, SCDC’s computer system cannot retrieve the names or numbers of all inmates referred to the ICS program; the number of women inmates referred to Geo Care for inpatient psychiatric services; the number of inmates who have made serious suicide attempts; or the number of inmates whose psychotropic medications have expired without being timely renewed.

In summary, the evidence in this case shows that the recordkeeping system for SCDC is outmoded, poorly maintained, and not readily accessible to all staff. The Court finds that SCDC’s failure to maintain accurate and complete mental health treatment records represents a substantial risk of serious harm to mentally ill inmates.

5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation

In evaluating this factor, some of the same concerns overlap with those of the previous factor – maintenance of accurate, complete, and confidential mental health treatment plans. The Court, however, will note three specific issues that raise further concerns. First, Medication Administration Records (“MAR”) of mentally ill inmates provide crucial information upon which psychiatrists rely. SCDC uses standard MAR forms where nurses are required to sign their initials to confirm that medication was provided and administered. At trial, various MARs were introduced indicating the absence of initials and absence of any record that medications were provided at all. This indicates either the medication was not provided or the nurses failed to maintain accurate records. For example, in October and November 2008, inmate Jonathan Mathis was prescribed one medication to be taken twice a day and two other medications to be taken once a day. From his MAR, however, it appears he received no medications either month, without explanation.

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Although counselors monitor MARs, the Court agrees with Dr. Patterson that SCDC counselors are not qualified to do so, as evidenced by counselor audits showing deficient MARs. Ms. Delgado acknowledged that a failure to adequately monitor MARs has no effect on a counselor’s audit score. For example, the only audit that one Lieber counselor has ever passed was an audit in which 14 of the 15 MARs reviewed for which she was responsible were found incomplete or outdated.

The second issue of concern involves the suicide of Robert Hamberg. SCDC records show that Mr. Hamberg’s morning medications had expired – specifically his anti-psychotic medicine Geodon – which he was supposed to receive twice a day. Nevertheless, his counselor

was still recording that he was compliant with his medication – that he was receiving it in the mornings and evenings. Thus, Mr. Hamberg was only receiving half of his prescribed dosage of anti-psychotic medication. Mr. Hamberg committed suicide on June 9, 2010 at Perry Correctional Institution.

The third issue of major concern in the area of medication administration involves pill lines. As Dr. Patterson testified, medication compliance is especially difficult for many mentally ill inmates, due to medication side effects and the nature of their illness. At many institutions, pill lines occur between 3:00 - 4:00 a.m., and mentally ill inmates are often left to their own devices to timely awake, stand in line, and then take their medication. The timing, press of business, and lack of individual attention at the pill line lends itself to inmates failing to take psychotropic medications.

This Court finds that the failure to appropriately supervise, evaluate, and dispense psychotropic medications creates a substantial risk of serious harm to inmates with serious mental illness.

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6. A basic program to identify, treat, and supervise inmates at risk for suicide

a. The setting of Crisis Intervention ("CI") cells

At trial, Dr. Patterson identified seven mentally ill inmates at SCDC, in addition to Jerome Laudman, whose deaths from 2008-2011 were both foreseeable and preventable.¹¹ In his opinion, two common factors contributed to these deaths. First, crisis intervention cells are located in segregation units, not in a medical setting, and thus lack sufficient medical interaction

¹¹ Six of these were suicides. The seventh, Stephen Jeter, was not ruled a suicide, but his death was related to a failed suicide attempt. Moreover, the Court is aware that two more SCDC inmate suicides occurred while this trial was actually in progress, one at Lee and one at Lieber, with both decedents either on or should have been on the mental health caseload.

and treatment. For example, CI inmates are not being assessed daily for mental health purposes. As of the date of trial, SCDC policy only required that inmates in CI be seen Monday through Friday, excluding holidays, and this policy is often violated. Inmates in CI cells spend the entire day in those cells, and are held for long periods of time – typically one to two weeks – but sometimes longer. CI cells, like other SMU cells, are cold and filthy, with trash, blood, and feces scattered or smeared about. Inmates are placed naked in CI cells. They often are not provided a blanket, and when one is provided it often is not clean. CI cells do not have mattresses. Inmates sleep directly on a cold steel or concrete slab. Inmate Richard Patterson testified how he tore up his Styrofoam food trays, then spread the pieces on his concrete slab to serve as a form of mattress. In addition, most inmates in CI do not see a psychiatrist and are not allowed group therapy. Interaction with counselors is brief, limited, and not confidential.

For at least a three-year period, from 2008-2010, correctional officers at Lieber, at times with the acquiescence of mental health staff and at other times without their knowledge, routinely placed CI inmates naked in shower stalls, “rec cages,” interview booths, and holding cells for hours and even days at a time. Most of these alternative CI spaces did not have toilets and none were suicide resistant. Details of these placements are contained in Dr. Metzner and Patterson’s inspection report, entered into evidence, as well as in their testimony and the testimony of various inmates. SCDC’s own logs document over 100 of these alternative placements during the 27 months for which logs were provided.¹² The Court finds that the vast majority, if not all, of these placements were for inmates on crisis intervention. SCDC logs show that 55 of these placements at Lieber were for twelve hours or longer and 29 exceeded 24 hours. Inmate Isaac Anderson was confined over 86 consecutive hours in a Lieber rec cage from April

¹² SCDC could not locate Lieber SMU logs for several of the months requested.

2-6, 2009, with his first documented bathroom break coming after 42 hours in the cage. The interview booths and showers used for CI were often filthy and too small a space in which to lie down. Correctional officers brought CI inmates “finger food” meals to these spaces. Since inmates were not always provided bathroom breaks, some were forced to urinate and defecate in the same spaces where they were fed. Moreover, the Court finds that the use of such inappropriate spaces for CI has not been limited to Lieber. Plaintiffs presented inmate testimony and other evidence that SCDC has placed CI inmates in such spaces at other institutions prior to 2008 and after 2010. For the reasons discussed, the Court finds that SCDC’s normal CI placements expose inmates with serious mental illness to a substantial risk of serious harm. The dehumanizing conditions of SCDC’s alternative CI placements expose inmates to even greater risk.

b. Lack of constant observation

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Second, SCDC’s policy does not require constant observation; rather, inmates in CI cells are checked on 15-minute intervals, documented in cell-check logs. The evidence before the Court contains proven instances of fabricated cell check logs. For example, the cell check log of inmate Edward Broxton noted that at 6:30 a.m. on February 2, 2010, he was eating breakfast, even though an hour earlier, at 5:30 a.m., Broxton had hanged himself in his CI cell at Lee. Many of the cell check logs for Jerome Laudman were initialed “GM,” although the only Lee Supermax correctional officer with those initials denied making the entries or authorizing anyone to use his signature. The SCDC Inspector General report on the drug overdose suicide at Perry of inmate James Bell documented evidence that his cell check logs had also been falsified. To make matters worse, on the Saturday before Bell’s suicide his aunt, in an upset state, phoned SCDC to warn them of a “goodbye letter,” suicidal in nature, she had received from her nephew.

SCDC mental health staff did not check on Bell until two days later, on Monday afternoon, when a counselor found him dead in his cell.

SCDC's expert, Dr. Haas, agreed with Dr. Patterson and Dr. Metzner that inmates on suicide watch require continuous observation. In 2008, inmate Brian Schriefer committed suicide while on CI at Gilliam by stuffing either toilet paper or a paper gown down his throat. As a result of Schriefer's death, SCDC stopped distributing gowns to CI inmates, instead requiring them to remain naked while in CI. SCDC did not change its policy, however, on continuous observation of suicidal inmates. Continuous observation would have prevented Schriefer's death.

The Court finds that SCDC's suicide prevention and crisis intervention practices create a substantial risk of serious harm to seriously mentally ill inmates.

7. Summary of objective component

As detailed above, this Court finds that the evidence in this case has proved SCDC's mental health program is inherently flawed and systemically deficient in all major areas. The Court further finds that a major contributing factor to the deficiencies in the SCDC program is the lack of a formal, comprehensive quality management program.

Finally, having observed the testimony of the psychiatric and correctional experts for both Plaintiffs and Defendants, this Court finds Plaintiffs' experts more credible. In part, this finding is due to a comparison of their credentials and experience; in part, due to their relative persuasiveness on the witness stand; and in part, due to the wide disparity between Plaintiffs' and Defendants' experts in case preparation and particular knowledge of the SCDC system.

Based on the testimony of these experts and the other evidence presented at trial, the Court finds that SCDC's mental health program exposes inmates with serious mental illness to a

substantial risk of serious harm. Plaintiffs have therefore satisfied the objective component of the deliberate indifference standard.

B. Subjective Component

The subjective component of the deliberate indifference standard requires proof that SCDC knew that Plaintiffs were exposed to a substantial risk of serious harm, but failed to take reasonable measures to abate the risk. *Farmer*, 511 U.S. at 847. The subjective component should be determined in light of the prison authorities' "attitudes and conduct at the time suit is brought and persisting thereafter." *Id.* at 845-846.

The evidence is overwhelming that SCDC has known for over a decade that its system exposes seriously mentally ill inmates to a substantial risk of serious harm. In 1999, SCDC retained Dr. Patterson (Plaintiffs' expert), through a grant, to inspect its mental health program. His report, issued in 2000, characterized the program as being in a state of "profound crisis." In October 2000, a Joint Legislative Proviso Committee report concluded that "inmates with mental illness are not receiving adequate treatment . . . and oftentimes leave prisons worse off than when they entered." In April 2003, a South Carolina Task Force whose members included three former SCDC Directors issued a report that concluded Gilliam was "clearly inadequate." In May 2003, the South Carolina Department of Mental Health issued a report on SCDC's mental health program, noting "[t]he lack of psychiatric coverage has resulted in a critical situation, with extremes of poor care, inhumane treatment, and dangerousness" In September 2003, SCDC Director Jon Ozmint, in an application for technical assistance, stated that "[t]he current plight of persons with mental illness at SCDC is at a crisis level." In June 2005, the Plaintiffs filed their Complaint in this case, alleging constitutional deficiencies in SCDC's program. From 2006-2010 Plaintiffs' experts issued eight site inspection reports criticizing conditions in SCDC

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facilities. In October 2007, SCDC psychiatrist Dr. Michael Kirby wrote a letter to his supervisor noting several serious problems with SCDC's mental health system. In June 2008, SCDC investigator Lloyd Greer issued his report on the death at Lee Supermax of Jerome Laudman. From 2008-2010, Lieber SMU logs documented the use of shower stalls and other inappropriate spaces for CI placements. In 2009-2010, SCDC was aware that the counselor shortage at Perry created serious deficiencies in the delivery of mental health services. In January 2010, a United States Department of Justice report was highly critical of SCDC's medication management and administration practices. SCDC's own counselor audits from 2010-2011 revealed numerous unsatisfactory practices and major deficiencies. January 2012 internal data showed counselor-to-patient ratios at many SCDC facilities that were excessively high. Finally, through the discovery process in the litigation of this case from 2005-2012, SCDC was made aware of the serious allegations raised by Plaintiffs and their experts, many of which are supported by SCDC's own records.

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The Court finds from this evidence that SCDC knows and has known, since before this lawsuit was filed, and persisting thereafter until the time of trial and even to present date, that its mental health program is systemically deficient and exposes seriously mentally ill inmates to a substantial risk of serious harm.

That, however, does not end the analysis. The second element of the subjective component focuses on action: has SCDC taken reasonable measures to abate the risks of which it is aware? The evidence shows that from 1999 until the filing of this action in 2005, SCDC did virtually nothing to address, much less eliminate, the substantial risks of serious harm to which class members were exposed. What limited action SCDC has taken since the filing of this lawsuit has had little to no effect in abating the unconstitutional deficiencies this Court has

found. “[T]o rely on intervening events occurring after suit has been filed the defendants must satisfy the heavy burden of establishing that these such events ‘have completely and irrevocably eradicated the effects of the alleged violations.’” *Thomas v. Bryant*, 614 F.3d 1288, 1320-21 (11th Cir. 2010).

SCDC has failed to meet this “heavy burden.” At trial SCDC identified the measures it has taken since 2005 to improve its mental health program. These include the hiring of two administrators and some administrative support staff, an increase in psychiatric staff FTEs, a reorganization of group therapy, a new protocol for addressing self-injuring behavior (“SIB”), mental health dorms, increased use of tele-psychiatry, new training programs for clinical and security staff, and counselor audits.

The Court finds that these are small steps that have had little impact on the systemic deficiencies in SCDC’s mental health program. The mere hire of administrators to replace other administrators is not necessarily an improvement. Additional administrative support staff does not address the dire need for more clinical staff. Since 2008, SCDC’s psychiatric staff has remained relatively flat and currently consists of 5.5 FTEs, although this Court has found that at least 14.5 FTEs are needed. As discussed, counselor and psychologist FTEs are far too low. Reorganized or not, group therapy sessions are frequently cancelled and unavailable for most inmates in segregation and crisis intervention. SCDC introduced no persuasive evidence that its new, decentralized SIB protocol has improved SIB-related issues. SCDC’s concentration of some mentally ill inmates in designated dorms is no substitute for an adequately staffed mental health program. At the time of trial, SCDC had not implemented expanded tele-psychiatry services, but had merely requested a feasibility study. SCDC’s training programs are limited in scope and poorly attended. Counselors are the only mental health clinicians subject to formal

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audits, and those audits, though limited in scope, reveal alarming deficiencies. Despite a low bar for passing, many counselors fail their audits, some repeatedly.

Half-hearted measures will not foreclose a finding of deliberate indifference. “Patently ineffective gestures purportedly directed towards remedying objectively unconstitutional conditions do not prove a lack of deliberate indifference, they demonstrate it.” Standards Order at 13, (quoting *Coleman v. Wilson*, 912 F. Supp. 1282, 1319) (E.D. Cal. 1995)). See also *Thomas*, 614 F.3d at 1320 (11th Cir. 2010) (“practices may be reinstated as swiftly as they were suspended”). The steps SCDC has taken have been small ones, characterized by SCDC itself as “band aids,”¹³ many of which were instituted shortly before and even during trial, that have failed to adequately address the known systemic deficiencies in its mental health program. The SCDC mental health program needs far more than band aids, and the Court finds that the measures taken by SCDC to correct its systemic deficiencies are neither reasonable, timely, nor effective. Plaintiffs have therefore satisfied the subjective component of the deliberate indifference standard.

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35 II. REMEDY TO ADDRESS CONSTITUTIONAL VIOLATIONS

A. Overview

In devising a remedy for the constitutional deficiencies at SCDC, the Court is required to balance two competing interests. First, it is not the role of this Court to micromanage the daily administration of the mental health program at SCDC. Moreover, this decision comes in a time of economic recession and heavy scrutiny of governmental expenses. However, “[c]ourts may not allow constitutional violations to continue simply because a remedy could involve intrusion into the realm of prison administration.” *Brown v. Plata*, 131 S.Ct. 1910, 1928-29 (2011).

¹³ SCDC’s June 8, 2009 Memorandum on Applicable Standards contended that SCDC had a “well-developed mental health system . . . in place for decades,” that needed nothing more than “band aids or other minor remedies.”

Additionally, the economic “cost of protecting a constitutional right cannot justify its total denial.” *Bounds v. Smith*, 430 U.S. 817, 825 (1977). “A plea of lack of funds is an insufficient justification for the failure of the executive department” to provide constitutionally mandated treatment programs. *Crain v. Bordenkircher*, 176 W.Va. 338, 364, 342 S.E.2d 422, 449 (1986), (quoting *Moore v Starcher*, 167 W.Va. 848 - 853, 280 S.E.2d 693, 696 (1981)).

Second, under the separation of powers doctrine, this Court may not usurp the authority of other branches of government. The separation of powers doctrine, however, “is not fixed and immutable.” *State v. Langford*, 400 S.C. 421, 434, 735 S.E.2d 471, 478 (2012). On the contrary, the doctrine contains “grey areas” and an “overlap of authority” among governmental branches. *Id.*

“Separation of powers does not require that the branches of government be hermetically sealed; the doctrine of separation requires a cooperative accommodation among the three branches of government; a rigid and inflexible classification of powers would render government unworkable.” At its core the doctrine therefore “is directed only to those powers which belong exclusively to a single branch of government.”

Id. (quoting 16A Am.Jur.2d, *Constitutional Law* § 244, 246).

In *Blaney v. Cmmr. of Corrections*, 374 Mass. 337, 372 N.E.2d 770 (1978), following defendants’ submission of deficient plans to remedy prison conditions, the court entered a remedial order giving explicit directions for defendants to follow. The court rejected defendants’ argument that the order violated separation of powers, noting that courts have power to direct public officials to carry out their lawful obligations. 374 Mass at 339-42, 372 N.E.2d at 773-74. “As to judges’ authority to fashion detailed orders to correct established violations of constitutional rights . . . [s]uch functions are judicial, and in no way usurp the power of the executive.” 374 Mass. at 342-43, 372 N.E.2d at 774, citing *Swann v. Charlotte-Mecklenburg*

County Bd. of Educ., 402 U.S. 1, 15 (1971); *U.S. v. Montgomery County Bd. of Educ.*, 395 U.S. 225, 234-36 (1969). See also *In re K.C.*, 325 Ill. App. 3d 771, 779-80, 759 N.E.2d 15, 23 (2001) (“When the legislature creates a statute that contemplates an interplay between the courts and the executive branch, court orders directing the actions of the executive agencies do not violate the doctrine of the separation of powers.”); *Crain*, 176 W.Va. at 364, 342 S.E.2d at 449 (where a court ordered the West Virginia Department of Corrections to implement an extensive remedial plan addressing constitutionally deficient prison conditions.); *Haley v Barbour Cnty.*, 885 So. 2d 783, 790 (Miss. 2004) (noting court regulation of the number of inmates a county may deliver to a prison does not violate separation of powers.); *Massameno v. Statewide Grievance Comm.*, 234 Conn. 539, 567, 663 A.2d 317, 333 (1995) (stating a court does not violate separation of powers doctrine by supervising and disciplining executive branch prosecutors.)

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Finally, this Court is bound to uphold the South Carolina Constitution and protect the rights of the mentally ill inmates at SCDC. Moreover, it is the action of a circuit court that triggers the placement of an inmate into the custody of SCDC, under Court authority, and thus this Court has the inherent power - and responsibility - to see that the imprisonment of that inmate complies with constitutional mandates. The Court is convinced that to view the evidence put forth in this case and then do nothing could be a great miscarriage of justice.

To address the constitutional deficiencies in the mental health system at SCDC, Plaintiffs have proposed a remedial plan comprised of three components. First, SCDC would be required to submit a written plan for remedying the systemic deficiencies identified by the Court. Second, SCDC must rely upon factors and guidelines identified by the Court in creating this plan, which the Court will then review and either approve or disapprove. Third, the Court will retain jurisdiction of this case and appoint expert monitors and/or a special master who will report

periodically to the Court. SCDC has raised objections to this plan, arguing that it constitutes an impermissible burden shift and is violative of the separation of powers doctrine.

The Court denies SCDC's objections. It would be highly impractical for Plaintiffs to identify and create a plan to implement changes to the mental health system at SCDC. Rather, once the Court has ruled, SCDC is in the best position to propose steps and changes to its existing system. *See Alexander S. v. Boyd*, 876 F. Supp. 773, 804-04 (D.S.C. 1995) (where a court ordered the South Carolina Department of Juvenile Justice to submit remedial plan within 120 days of order); *Crain*, 176 W.Va. at 341, 342 S.E.2d at 426 (where a court ordered the West Virginia Department of Corrections to submit remedial plan within 180 days of order). As a result, the Court adopts Plaintiffs' proposals and requires SCDC to submit a written plan to the Court within 180 days of the date of the Final Order in this case. In executing the remedial plan to be submitted by SCDC, the Court will retain jurisdiction but also intends to appoint a monitor who will report periodically to the Court. The Court will provide the parties, through motions, an opportunity to suggest the appropriate appointee(s) to oversee this process.

B. Remedial Factors and Guidelines

In formulating specific factors and guidelines for SCDC's remedial plan, the Court will again utilize the *Ruiz* factors above, along with additional sub-factors and components listed thereunder. In devising a plan to remedy the constitutional deficiencies identified by the Court, SCDC shall be directed in the Order to prepare a written plan that includes, at a minimum, the following:

1. The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care

- i. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of increasing the number of inmates recognized as mentally ill and being admitted to the mental health program by a minimum of two percentage points (14.9 percent of the inmate population);
- ii. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;
- iii. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and
- iv. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.

2. The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC

a. Access to Higher Levels of Care

- i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefor;
- ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefor;
- iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam

Psychiatric Hospital, or its demolition for construction of a new facility;

- iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and
- v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.

b. Segregation

- i. Provide access for segregated inmates to group and individual therapy services;
- ii. Provide more out-of-cell time for segregated mentally ill inmates;
- iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;
- iv. Provide access for segregated inmates to higher levels of mental health services when needed;
- v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;
- vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and
- vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

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c. Use of Force

- i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;
- ii. The plan will further require that all instruments of force, (e.g, chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;
- iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;
- iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;
- v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;
- vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;
- vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;
- viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;
- ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;
- x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and

- xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.

3. **Employment of a sufficient number of trained mental health professionals**

- i. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;
- ii. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;
- iii. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;
- iv. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;
- v. Require appropriate credentialing of mental health counselors;
- vi. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and
- vii. Implement a formal quality management program under which clinical staff is reviewed.

4. **Maintenance of accurate, complete, and confidential mental health treatment records**

- i. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:
 - Names and numbers of FTE clinicians who provide mental health services;

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- Inmates transferred for ICS and inpatient services;
- Segregation and crisis intervention logs;
- Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);
- Use of force documentation and videotapes;
- Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;
- Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;
- Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;
- Quality management documents; and
- Medical, medication administration, and disciplinary records.

- ii. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.

5. **Administration of psychotropic medication only with appropriate supervision and periodic evaluation**

- i. Improve the quality of MAR documentation;
- ii. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;
- iii. Review the reasonableness of times scheduled for pill lines; and
- iv. Develop a formal quality management program under which medication administration records are reviewed.

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6. A basic program to identify, treat, and supervise inmates at risk for suicide

- i. Locate all CI cells in a healthcare setting;
- ii. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;
- iii. Implement the practice of continuous observation of suicidal inmates;
- iv. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;
- v. Increase access to showers for CI inmates;
- vi. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;
- vii. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and
- viii. Implement a formal quality management program under which crisis intervention practices are reviewed.

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CONCLUSION

Even the most brief and facile view of the evidence put forth by Plaintiffs in this case reveals obvious, significant, and longstanding problems with mental health services delivery at SCDC. Prior to trial, this Court tried its very best to bring the parties together for settlement purposes, even requiring the Director of SCDC and the guardian for the Plaintiffs, attorneys for both sides, and other interested parties to meet in an effort to resolve the case. The Court was not present for these discussions and thus cannot determine why they were unsuccessful.

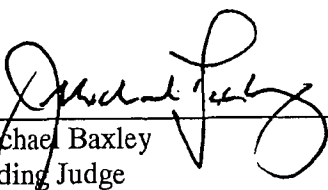
We are now eight years into this litigation. Rather than accept the obvious at some point and come forward in a meaningful way to try and improve its mental health system, Defendants

have fought this case tooth and nail—on the facts, on the law, on the constitutional issues, portraying itself as beleaguered by the burdensomeness of Plaintiffs’ discovery, and generally harrumphed by the invasive nature of Plaintiffs’ counsels’ tactics and strategies. This Court has spent dozens of hours in hearings and conferences in an effort to resolve discovery disputes, most of which involved delay, missed deadlines, and recalcitrance on the part of the Defendants.

This Court can never criticize any party for a vigorous exercise of offense or defense in civil litigation, for such is the foundation of our adversarial system of justice. But justice in this case is not really about who wins or loses this lawsuit. The hundreds of thousands of tax dollars spent defending this lawsuit, at trial and most likely now on appeal, would be better expended to improve mental health services delivery at SCDC.

For the reasons set forth above, the Court grants judgment in favor of the Plaintiffs and orders SCDC to submit a proposed written remedial plan consistent with this Order.

IT IS SO ORDERED.



J. Michael Baxley
Presiding Judge
Complex Jurisdiction

Hartsville, South Carolina

January 8, 2014

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Appellate Case No. 2013-002415

Brook Waddle,

Appellant,

v

South Carolina Department of Health
and Human Services,

Respondent.

CERTIFICATE OF SERVICE

Patricia L. Harrison certifies that she has served *Appellant's Amended Initial Brief* and *Amended Designation of Matter* the above captioned case on the Respondent by United States mail to the Office of General Counsel, SC Department of Health and Human Services, PO Box 8206, Columbia, SC 29202-8206 on May 28, 2014.



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May 28, 2014

The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
PO Box 11629
Columbia, South Carolina 29211

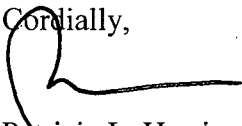
RE: **Brook Waddle v. SC Department of Health and Human Services**
Appellate Case No. 2013-002415

Dear Ms. Kitchings:

Enclosed is the original *Appellant's Amended Initial Brief* and *Amended Designation of Matter* along with a Certificate of Service. Please clock the enclosed copies and return them in the stamped envelope provided.

Thank you for your consideration and assistance in this matter.

Cordially,



Patricia L. Harrison

Enclosures
PLH:jnh

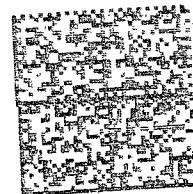
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