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IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals
APPEAL FROM THE ADMINISTRATIVE LAW COURT

Case No. 2013-000762

73713

RECEIVED

SEP 30 2014

SC Court of Appeals

Richard Stogsdill,
Appellant,

v.

South Carolina Department of Health
and Human Services,
Respondent.

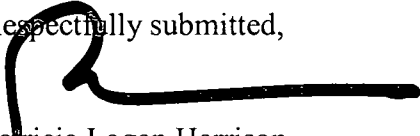
APPELLANT'S MOTION TO FILE CORRECTED MEMORANDUM OF LAW
IN SUPPORT OF APPELLANT'S PETITION REQUESTING REHEARING

This Motion is filed pursuant to Rule 240 of the South Carolina Rules of Appellate Practice. Rule 240(c) provides that where the facts relied upon in support of motion are not contained in the Record on Appeal or Appendix, the parties shall file affidavits and other documents in support of their positions. Appellant respectfully moves, with the consent of opposing counsel, for permission to file Appellant's Corrected Memorandum in Support of Petition Requesting Rehearing. The grounds for this Motion are that the Rules required Appellant to file his Petition within ten days of the filing of this Court's decision and he did not receive Respondent's Petition (filed by mail) until September 24, 2014. Due to the short time to file the Memorandum that was due on September 25, 2014 and due to other deadlines that week, errors were made by Appellant's counsel, which Appellant wishes to correct. Also, Exhibit 7, referred to in the original Memorandum, may have been accidentally omitted in the copies filed with the

Court and opposing counsel. The attached Memorandum corrects these errors (primarily grammatical) and includes Exhibit 7. It does not contain any arguments not contained in the original Memorandum.

Appellant respectfully prays that this Court will grant permission to file this Corrected Memorandum and will accept the Memorandum as filed.

Respectfully submitted,



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Attorney for Appellant

September 30, 2014

IN THE STATE OF SOUTH CAROLINA

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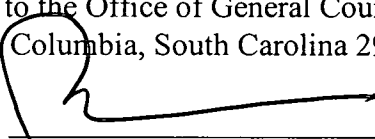
Richard Stogsdill,
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CERTIFICATE OF SERVICE

Patricia Logan Harrison hereby certifies that she has served Appellant's Corrected Memorandum in Support of Petition Requesting Rehearing in the above captioned case on the Respondent by hand delivery to the Office of General Counsel, SC Dept. of Health and Human Services at 1801 Main Street, Columbia, South Carolina 29201 on September 30, 2014.



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September 30, 2014

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

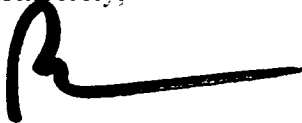
Re: **Richard Stogsdill v. SCDHHS**
Lower Court Case No. 2010ALJ080774AP
Appellant Case No. 2013-000762

Dear Ms. Kitchings:

Enclosed are original *Appellant's Motion to File Corrected Memorandum*, the proposed *Corrected Memorandum* and Certificate of Service along with six copies of all and a copy to be clocked. Also enclosed is a check for \$25.00 to cover the filing fee for the *Motion*.

We appreciate the Court's kind consideration of this *Motion*.

Sincerely,



Patricia L. Harrison

Enclosure

c: Richard G. Hepfer, Esq.

PLH:jnh

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APPELLANT'S CORRECTED MEMORANDUM OF LAW IN
SUPPORT OF PETITION REQUESTING REHEARING

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Introduction

Appellant, Richard Stogsdill, received Respondent's Memorandum requesting rehearing on September 24, 2014. In order to preserve Richard's right to appeal, in the event that this Court should grant Respondent's Motion for a Rehearing, or the possibility of a subsequent appeal to the South Carolina Supreme Court, Appellant must respectfully and regrettably file this protective motion. Pursuant to Rule 221(a) of the South Carolina Appellate Court Rules, Richard Petitions this Court for a Rehearing of its Opinion issued on September 10, 2014, since Respondent's Memorandum gives every indication that the agency does not, in good faith, have any intention of assessing his need for services, giving the "greatest of deference" to the opinion of his treating physician and other qualified medical professionals, as required by *Olmstead*. Richard's father has died during this litigation and the bottom line is that he will not have the supports that are needed for him to remain at home if his services are reduced. For these reasons, Richard respectfully requests that this Court reconsider its decision as it relates to the following issues:

- | | |
|---------|--|
| Issue 2 | The mandate of the United States Supreme Court requiring DHHS to give the "greatest of deference" to his physician's orders. (Appellant's Brief at 18 - hereinafter referred to as "AB at 18") |
| Issue 4 | DHHS' failure to comply with the South Carolina Administrative Procedures Act (SC APA) and the "reasonable standards" requirement of the Medicaid Act (AB at 35) |
| Issue 5 | Violations of Richard's Due Process rights (including the right to notice) and the Separation of Powers requirement of the South Carolina Constitution (AB at 41) |
| Issue 6 | DHHS' violations of the "reasonable promptness" requirement of the Medicaid Act contained at 42 U.S.C. 1396a(a)(8) (AB at 47) |
| Issue 7 | DHHS' violation of the "comparability" requirements of the Medicaid Act at 42 U.S.C. 1396a(a)(10)(B) (AB at 48) |

This Motion is protective, because the issues Richard asks this Court to reconsider are currently pending in a parallel case in the federal district court in *Richard Stogsdill et. al. v. Sebelius*. Jury selection is now set for November 5, 2014. Case No. 3:12-cv-007-JFA. The parties have fully briefed that case in the federal district court and have filed motions for summary judgment, which have not yet been ruled upon by that court. Exhibit 1. Federal Court Docket Sheet in *Richard Stogsdill et. al v. Sebelius*.¹

A fair hearing was held in Richard's first appeal on June 29, 2009 (more than 120 days after Richard requested a fair hearing).² *Id.* At that hearing, the State failed to provide any evidence or testimony from a qualified medical source. Exhibit 2. But, Richard presented live testimony from a nurse who had provided services to him and was very familiar with his needs and his condition. Exhibit 2. On November 16, 2009 (more than 180 days after Richard filed his request for a fair hearing), DHHS Hearing Officer Loomis issued an order that contained the following Findings of Fact:

- No one involved in the January 2009 care planning was a licensed medical, nursing or social work professional.
- DDSN did not solicit input from Richard's treating physician.

¹ The federal lawsuit was filed on January 1, 2012, nearly three years after DHHS failed to issue a final, appealable decision on his need for additional Medicaid waiver hours. He remained trapped in the Executive Branch hydraulic, as his condition has continued to deteriorate. *R.S. v. DHHS*, 09-MISC-017. R. 31. (Abbreviation "R." refers to the Record on Appeal filed in this Court.)

² *Doe v. Kidd*, a case in which DDSN and DHHS are defendants, is controlling law in this case. In 2007, the Fourth Circuit held that the "reasonable promptness" mandate at 42 U.S.C. 1396a(a)(8) requires these South Carolina agencies to provide requested medical assistance within 90 days. 42 C.F.R. 431.244(f). *Doe v. Kidd I*, 501 F.3d 348, 356 (4th Cir. 2007) ("...federal and state regulations and manuals define reasonable promptness as forty-five days or ninety days, depending on the applicant. *See, e.g.*, 42 C.F.R. § 435.911") and *Doe v. Kidd II*, Case No. 10-1191, fn 2 (4th Cir. 2011).

- Richard's treating physician determined that he required 2 caregivers for 8 hours a day (total 16 hours a day).
- Richard continued to need the number of respite hours he was receiving in 2009.
- Richard's needs for socialization were not being met.

R. at 35. DHHS Hearing Officer Loomis issued the following Conclusions of Law in Richard's fair hearing appeal in 2009:

- The Waiver requires that an "individual written plan of care will be developed by qualified individuals..."
- DDSN did not solicit input from Petitioner's treating physician during the January 2009 care planning process.
- The "People Providing Input" during Petitioner's January 2009 care planning process did not rise to the professional level of "qualified individuals" needed to fully evaluate a care plan and they were not "fitted (as by training and experience)" for the care planning process. Therefore, the issue of Petitioner's personal care services for the remainder of the 2009 care plan is remanded to DDSN for additional care planning that takes Dr. Joseph's June 29, 2009, affidavit recommendations into account."
- The level of Respite services authorized in the 2009 care plan was appropriate.
- The DDSN Service Coordinator should have recognized the need for Adult Companion services as articulated in the January 2009 annual plan.
- The hearing officer remanded the issue of the number of hours of Attendant Care services Richard needed to DDSN.
- Subject matter is lacking on the issue of the failure to promulgate regulations and to establish reasonable standards ("This tribunal does not have subject matter jurisdiction to determine any issues other than those specifically associated with the actual provision of Medicaid services." R. at 41.)

R. at 37 -39. That was an "interlocutory" order that Richard could not appeal to the Administrative Law Court or the Judicial Branch. More than five years later, Richard's plea for help seems to have been lost in a bizarre and complicated state-wide scheme to drastically reduce the services severely disabled persons living at home, based on untrue claims of "budget reductions."³ On remand to DHHS, some time after November 16, 2009, DDSN determined that

³ Rule 201 of the South Carolina Rules of Evidence require this Court to take judicial notice of facts that are not "subject to reasonable dispute" because they "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Rule 201(b). That Rule provides that the court must take judicial notice "if a party

Richard needed an additional 15 hours a week of Adult Companion Services. Exhibit 2. Affidavit of Nancy Stogsdill dated September 25, 2014. But no written decision was issued on remand and

requests it and the court is supplied with the necessary information.” The websites of the South Carolina Comptroller General and the Governor of South Carolina are sources whose accuracy should not be questioned. The Comptroller documented that in FY 2010 DHHS allowed \$225,945,013 of funds allocated by the General Assembly to “lapse.” See page 4 at <http://www.cg.sc.gov/publicationsandreports/Documents/Press/2010YearEndPressRelease.pdf>. Had these funds been used, as intended by Congress in the American Recovery and Reinvestment Act (ARRA, P.L. 111-5), to maintain and expand Medicaid services, they could have provided \$1,129,725,000 of Medicaid services, during FY 2010 alone (with the 4 to 1 federal match in effect during the years the ARRA funds were paid to DHHS, from 2009 to 2011). This Court may also take judicial notice of the fact that during the most recent fiscal year, DHHS failed to spend \$280 million of funds that were allocated by the General Assembly, nearly 25% of its state budget. See

<http://www.cg.sc.gov/publicationsandreports/Documents/Press/2014YearEndPressRelease.pdf> at page 4. These unexpended funds could have produced more than \$800 million in income, had they been matched with federal dollars, at the current 70% match rate, to provide health care services to South Carolinians like Richard. Respondent’s claims of lack of funding ring hollow and leave real live people like Richard and his mother on the edge of their worst nightmares coming true. See *Unequal Justice for South Carolinians with Disabilities* letter and report at R. 484 and 486. The truth matters. And the truth is that neither DHHS nor DDSN have suffered from the lack of funding since Richard’s 2009 appeal was filed. The month that DHHS submitted the waiver application to CMS in 2009, claiming to have to reduce services due to lack of funding, DDSN was sitting on a \$7.845 million “excess funds” account. R. 882-884. Even though DDSN transferred \$5.944 million of these funds, for purposes not approved by the General Assembly, while that legislative body was adjourned. R. 879. Even so, by the end of FY 2014, according to the Governor’s Executive Budget for FY 2015, DDSN had accumulated more than \$9 million in excess funds by the end of FY 2014. These funds are believed to be held in an account not subject to oversight by the General Assembly. (According to DDSN Commission minutes from January, 2014, legal counsel at the Budget and Control Board advised DDSN to hold these “excess” funds to cover “a pending lawsuit.” See <http://www.ddsn.sc.gov/DDSNCCommission/Documents/meeting%20minutes/01%20January%2016,%202014%20Commission%20Mtg%20Minutes.pdf>.) Over and above these “excess funds,” the General Assembly approved state funding of \$14.8 million in new permanent funding to be paid to DDSN for FY 2015. See

<http://ddsn.sc.gov/DDSNCCommission/Documents/meeting%20minutes/06%20%20June%2019,%202014%20Commission%20Meeting%20Minutes.pdf>. This could produce more than \$45 million in additional funding for the agency during FY 2015 alone, if these funds are spent, as intended, to provide Medicaid waiver services to disabled persons like Richard. Yet, DHHS continues to work to defeat Richard’s battle to remain in the community in its latest Memorandum.

no notice of appeal of the number of hours approved was provided to Richard or his counsel. No one at DDSN or DHHS made any attempt to comply with the hearing officer's order requiring that input be solicited from Richard's treating physician, Dr. Joseph, in preparing his plan of care.

Instead, less than one month later, in December, 2009, DDSN sent out an announcement to Medicaid waiver participants that a 28 hour cap was being imposed on Personal Care Attendant and Adult Companion Services, caps were being imposed on Respite services and that Physical Therapy, Occupational Therapy and Speech and Language Services were being terminated as waiver services. It is uncontested that this announcement did not meet the notice requirements of 42 C.F.R. 431.210.⁴ In addition, instead of allocating hours annually, under the "new" waiver, hours were to be allocated either weekly or monthly. This change prohibited the "saving" or "banking" of hours that waiver participants need in the event of a lengthy illness or

⁴ The Order of DHHS Hearing Officer Bryson states that:

I believe that the Petitioner is arguing that he should have been given advance notice of the exact reduction in services and a description of the hearing rights that apply. He is right. Full and descriptive notice of the agency action to be taken and the appeal rights attached should go to the participant in advance of the action to be taken. The notice should go to the participant, not just his service providers. Fortunately, the Reconsideration process in this case gave the DDSN another chance to fully describe the actions to be taken. R. 23.

Yet the "reason" for the reductions provided on the "notices" was that Richard "moved out of state." R. Whether or not he had, indeed moved out of state was the only issue that should have been decided at the 2010 hearing. 42 C.F.R. 431.210. At the hearing in July, 2009, Richard had presented live testimony of medical necessity from a nurse, David Todd, who had provided services to him for years. In addition Richard introduced affidavits from his treating physician, Dr. Joseph, and his provider of psychological services, Lennie Mullis. But the transcript of the hearing held in 2009 was not included in the Record on Appeal prepared by DHHS in 2010, nor were the exhibits that he presented to the hearing officer at that hearing. Exhibit 2. Affidavit of Nancy Stogsdill dated September 25, 2014.

other absence of the family caregiver. In that event, under the amended waiver, Richard's only option would be to succumb to his mother's greatest fear in life - the fear she could not even bring herself to speak out loud about - her son being admitted to a DDSN ICF/MR (nursing facility for persons who have mental retardation or a related disability). The number of days allowable in this institutional setting was not capped, and under the "new" waiver, Richard can receive an unlimited number of days in an ICF/MR - the most expensive - and dangerous - setting in DDSN's system. R. 324, 484, 486.

According to the DDSN Commission minutes of May 21, 2009, these reductions were necessary "Due to budget cuts." R. 833. The State Medical Care Advisory Committee, which must review changes to the Medicaid waiver program, was informed by DDSN and DHHS staff that these caps and termination of services were necessitated "Due to the state's budget situation..." R. 844. These reductions and changes were made after the General Assembly adjourned for the year, and they were put into place before that legislative body returned to the State House. The decision to place caps on critical services was made by a few state employees, without even the local DSN Boards knowing the scheme that was afoot that would force waiver participants like Richard out of their homes and into DDSN congregate day and residential settings. R. 914.

Richard joined eight other DDSN Medicaid waiver participants in filing a Petition with the South Carolina Supreme Court in December, 2009, asking that Court to hear their Complaint in its original jurisdiction to prohibit DHHS from enacting these reductions and changes because

they were based on false claims of lack of funding.⁵ R. 337. But that Petition was denied and the caps and reductions for persons who had not filed an appeal were scheduled to be put into place beginning on January 1, 2010.

Richard filed a second request for a fair hearing on December 30, 2009, when he learned of the agency's intention to reduce all waiver participants' services. R. 943. It was necessary for him to file this state administrative appeal, to avoid his services being reduced, under the terms of the "new" waiver.⁶ On January 11, 2010, DDSN sent Richard Notices of Termination of

⁵ A year earlier, the South Carolina Legislative Audit Council had issued an audit finding that DDSN's financial information was "unreliable." R. at 667. The LAC found that DDSN "spent just \$7.6 million of the \$25.4 million appropriated to operate new beds," thereby losing the matching 70% federal funding for those dollars. R. at 720. According to LAC, DDSN made capital grants of more than \$23 million to local boards without authorization by the General Assembly during that time. R. at 722. DDSN granted the Babcock Center, a private corporation, \$2.4 million in one or more "infrastructure grants" to purchase a new administrative building and for other purposes during the period covered by the 2008 LAC Audit. R. at 722. DDSN requested appropriations for additional new beds in FY 09 "when it had not developed the beds it had received appropriations for in FY 05-06 and FY 06-07." Id. It was later disclosed that DDSN's largest private provider, the Babcock Center, had failed to pay fica taxes during much of 2007 and 2008 during a period when DDSN was transferring \$2.4 million to this private corporation in an "infrastructure grant" and the corporation owed DDSN more than \$2 million, according to the 2008 LAC Audit of DDSN. R. at 702 and 722. That recipient of tremendous DDSN "grant" funds (that could have been used, with a 70% federal match, to provide services for persons like Richard) sued the federal government seeking a refund of the penalties and interest it paid to the IRS. *Babcock Center v. U.S.A.*, C/A Nos. 3:11-01721-CMC, 3:11-03155-CMC (D.C.S.C. May 2, 2013). (A jury returned a verdict against the Babcock Center and Babcock Center has appealed to the United States Court of Appeals for the Fourth Circuit, where the case is pending. Case No. 13-2056 (4th Cir.)).

⁶ For the first time, in *Peter B. v. Sanford*, the federal district court issued a preliminary injunction preventing DHHS from reducing the services of DDSN waiver participants. The reductions in services of plaintiffs Michelle M. and Chip E., were scheduled to go into effect on January 1, 2010, but they filed an administrative appeal and a lawsuit in federal court. R&R of then Magistrate Judge Bruce Howe Hendricks dated November 24, 2011. 6:10-cv-00767 adopted *in toto* by order of Judge Michelle Childs on March 7, 2013. The caps were also not imposed in the case of B.H., but the threat was removed only after she filed a lawsuit in the federal court. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0656-AP (S.C.A.L.C. July 19, 2011) and *Hickey v.*

Services informing him that his Personal Care Services and Respite Services were being terminated. R. 925-926. The reason given for this action was that he “moved out of state.” Id. But, Richard has lived in the same house for over ten years. R. 315-316. These are the only notices in the Record.⁷ According to Mrs. Stogsdill, a notice of termination of services was also sent to “all of his suppliers,” but not to Richard, after he filed his administrative appeal in December 2009. Id.

On January 12, 2010, the Director of DDSN sent Richard a letter denying his request to exceed the new waiver limits. R. 940. In this letter, Dr. Buscemi confirmed that DDSN was treating the caps as a binding norm. She stated in her letter to Richard that “While we understand the hardship these changes may cause, *we are not at liberty to exceed the established limits.*” Id. (Emphasis added.)

But the honest truth was that the cost of the MR/RD Medicaid program actually increased by tens of millions of dollars in 2010, after these caps were imposed and PT, OT and Speech services were terminated from the waiver program. According to the MR/RD Medicaid Waiver filed with CMS by DHHS in 2004, the total cost of the program for 2009 was projected to be

Forkner, Case No. 4:10-cv-2696 (S.C.D.C. May 5, 2011). B.W. did not file a federal lawsuit, and DDSN reduced her services while her administrative appeal was pending, even though she was under age 21 and was entitled to all medically necessary services under the EPSDT mandate of the Medicaid Act. An emergency appeal in B.W.’s case was filed weeks ago in the Administrative Law Court, which still has not been ruled upon, and she still is receiving fewer hours than she was receiving when she filed her administrative appeal. *B.W. v. DHHS*, Exhibits 4, 5 and 6.

⁷ The burden of proof should have been on the agency in the second “fair hearing.” *Kegel v. State*, 113 N.M. 646, 648, 830 P.2d 563 (Ct. App. 1992). “One who pleads an affirmative defense has the burden of proving it.” 2 Am. Jur. 2d Administrative Law § 360. (“Generally, the burden of proof is on the party asserting the affirmative issue in an adjudicatory administrative proceeding.”)

\$217,252,605, with an average cost per participant of \$36,209. R. 236 and 891. Then, CMS sent a letter to DHHS, on November 9, 2009, approving the agency's request of \$278,661,600 to operate the program. Under the amended waiver program, the average annual cost per participant in 2009 was \$51,869, according to this application. R. at 75. A few months later, DHHS submitted a new application to CMS dated April 28, 2010, again reporting that the cost of the MR/RD Medicaid program during 2010 to be \$278,662,353.40, but this time DHHS reported that the average cost per participant would be \$44,232 (which was still an annual increase of \$8,023 per participant over the per capita cost in 2009.)

A hearing was held on May 11, 2010 on the appeal Richard filed December 30, 2009. R. 16. The "reasons" provided for the reduction of Richard's services had been (1) drastic budget reductions in funding, and (2) Richard moved out of state. But neither of the "reasons" provided in the "notices" were argued by DHHS at the hearing. The "notices" did not inform Richard that the issue at the "fair hearing" would be the medical necessity for his services that had been ordered by Dr. Thomas. At the hearing, DHHS presented only two witnesses. Neither of these witnesses had any medical training, they had never met Richard, and neither had reviewed any of his medical records or contacted his physician, had been as ordered by Hearing Officer Loomis.

At the hearing, Respondent presented Jacob Chorey and Dawn Shealy as their only witnesses. R. 275 to 303. Ms. Shealy held a Bachelor of Arts Degree in Sociology, but she had no medical training. R. 278-279 and 287. In her job, she did not perform any review of medical necessity of services. R. 280 and 281. She had never met Richard and she had no idea whether he could get out of bed, take a shower or feed himself. R. 282. She had not reviewed any medical records or communicated with his physician. Id. She determined that more respite hours were not

needed, because his mother only worked “part time” and “we just felt that 40 hours a week of respite was sufficient.” R. 284. She never inquired of anyone how many hours Richard’s mother worked a week. R. 285. According to Ms. Shealy:

Maybe the caps wasn’t - they aren’t good for all situations. Respite in the past and this is totally opinionated but respite in the past has been widely abused. I’m not saying that it is abused in this case but I’ve been working in the system for quite awhile. I worked as a service coordinator, a service coordination supervisor and I saw that respite, you know, has been abused in the past and that’s why I said that in some situations caps on services I think is a good thing.

R. 288.

Respondent’s second witness, Jacob Chorey, held a Bachelor’s of Science in Psychology and a Master’s of Arts in Counseling, but he had no medical training either. R. 291. He held the position of MR/RD Waiver Program Coordinator at DDSN. Id. Chorey began working for DDSN in September 2009, after DHHS submitted the waiver amendments, but he did not know why the caps were implemented. R. 294-295 and 302. According to Mr. Chorey, his role at DDSN was “to testify in these types of fair hearings to represent the Agency so even if I don’t have a direct role in the determination, I still would have a role in testifying to the processes that have been developed and any related information that I’m aware of.” R. 301. He had no personal knowledge of the funding issues associated with the waiver amendments or the events that led up to the decision to cap and terminate services.

At the hearing held on June 29, 2009, Richard had presented testimony from a nurse, David Todd, who had worked with him for years and was familiar with his condition and his needs. But this testimony was not included in the Record on Appeal prepared by DHHS. Exhibit 2. Nor was other testimony or exhibits included in the Record filed with the Administrative Law Court in 2010, despite the order remanding Richard’s 2009 appeal being “interlocutory.”

Richard's mother testified again at the 2010 hearing as to his condition and his need for services. R. 304- 329. She testified that when Richard finished high school, she had to quit her full time job and she was working six part time jobs, in order to be able to go home to help Richard during the day. R. 307-309. She testified that Richard would not be safe at the workshop operated by the Kershaw DSN Board, because he cannot protect himself from assault. R. 311. He would be required to spend his days isolated with persons who were unable cognitively to communicate with him and he would be assigned to a table. R. 310-311. Mrs. Stogsdill testified that Richard "would be devastated to have to go to a workshop" and it would be "unbearable" for him. R. 311.

Without objection from Respondent's counsel, Mrs. Stogsdill presented the affidavit of Lennie Mullis, who provides psychological services to Richard, and she described the services provided by Ms. Mullis. R. 312-313. (Affidavit at R. 917). Richard's mother described the deterioration in his physical condition since his PT and OT services were terminated and provided the hearing officer with an affidavit signed by his treating physician. R. 313-319. This affidavit was presented without objection from Respondent's attorney. R. 318. (At the start of the hearing, Respondent's counsel agreed that "I don't have any problems with the affidavits submitted for whatever probative value they have." R. 6. But, he reserved the right to "comment as they are admitted." Id.)

Richard's mother testified that Richard's treating physician, Dr. Joseph, had provided medical care to him for 22 years. R. 318. According to Mrs. Stogsdill, Dr. Joseph had watched Richard progress over the years, then he watched Richard "regress" due to "boredom and frustration" when the therapies he received at school were terminated. R. 319-319. She presented

the sworn affidavit Dr. Joseph had signed, without objection from DHHS' counsel. R. at 920.

According to Dr. Joseph's sworn affidavit, Richard's parents would "not be able to provide for his care without the supports that have been in place." R. 921. Even before the death of Richard's father, Dr. Joseph opined that "They are exhausted from the demands of daily caregiving responsibilities. Richard would be at risk of institutionalization if the needed home-based services are not provided." R. 921. He stated that Richard needed two caregivers for 8 hours a day (total 16 hours), because it takes 2 caregivers to safely lift him into and out of bed and into his wheelchair. R. 920. According to Dr. Joseph, in addition Richard needed 5 hours a day of adult companion services to replace the services that had been provided at school. Id. He agreed with Ms. Mullis that it would not be appropriate to place Richard in a congregate day program and that his health "would deteriorate" if he was living in an institutional setting. R. 920-921.

Mrs. Stogsdill testified that "it's desperate when we have to watch" Richard as he "sweats and moans" when he is suddenly stricken with muscle spasms. R. 320. When he goes to the doctor, Richard has to have "somebody on both sides of him" because "he just buckles" and will fall on the floor R. 321. If Richard's services were reduced, Mrs. Stogsdill testified that "I guess we'd try to find placement but from what I gather, there are no slots available." R. 322. She testified:

...that would kill Richard. That would kill Richard...that's not a life for somebody that is a normal mentally human being." R. 322. When asked what placement outside the home DDSN had offered, she responded "I guess it's the ICFMR."

R. 322. If that happened, Richard's mother testified that he "would object violently. And I mean he would - he wouldn't understand why we were doing it. He - I mean he would think that, what

happened, you know, what did I do? Why am I being punished?” R. 325.

Grounds for Motion for Rehearing Issues 2, 5, 6 and 7

At this point in the proceedings, Richard suggests that these issues should be heard, to the extent that they were not favorably addressed in this Court’s Order of September 10, 2010, by the federal district court. These issues have been fully briefed by the parties in that court, discovery has been taken and a date set for jury selection. Alternatively, Richard requests, without suggesting that he cannot pursue parallel claims in the federal court, that if this Court wishes to address these issues, the arguments Richard made in his Motion for Summary Judgement filed in the district court are provided for this Court’s review and consideration. Exhibit 7. (Due Process at p. 12 of Exhibit 7, “greatest deference” at pp. 21-22, Reasonable Promptness at p. 12-14, Comparability at p. 35)

Grounds for Motion for Rehearing on Issue 4

Grounds for reconsideration of Issue 4 contained in Appellant’s Brief at 35, are that the Court appears to have overlooked cases which clarify the limited scope of the *per curiam* opinion issued by the North Carolina Supreme Court in *Arrowood v. North Carolina Dept. of Health and Human Services* (353 N.C. 351, 543 S.E.2d 481 (N.C. 2001) (hereinafter referred to as *Arrowood II*) in ruling that DHHS does not have to comply with the rulemaking requirements of the South Carolina Administrative Procedures Act. Unfortunately, the arguments made by Respondent in its Memorandum[¶] requesting rehearing, make it clear that relief will not be provided through a remand to DDSN unless Respondent is ordered to comply with the APA to end the arbitrary and capricious manner and methods used by DDSN and DHHS to determine medical necessity for Medicaid services. So it is critical that this Court require Respondent to establish reasonable

standards for the operation of the ID/RD Medicaid Waiver program through the rulemaking procedures mandated by the General Assembly in the SC APA. It is also only fair and just, until such standards are established, that he be provided the services ordered by his physician. The medical need for those services has been established twice now in “fair hearings” where DHHS failed to provide evidence from any qualified medical source (or any medical source, qualified or not) to contradict the well supported treatment orders of Richard’s treating physician.

In *Doe v. Kidd II*, the United States Court of Appeals for the Fourth Circuit ruled that federal district courts “in the context of the Medicaid Act” are “invested with broad equitable powers to style any appropriate remedial relief.” Citing *Alexander v. Hill*, 707 F.2d 780, 783 (4th Cir. 1983) (permitting a district court to exercise its broad equitable powers in fashioning a remedy to address the continuing failure of a state to comply with Medicaid regulations). The Fourth Circuit noted in *Doe II* that in *Smith v. Miller*, the Seventh Circuit concluded that “no provision of the Medicaid Act or the Constitution restricts the authority of the courts to award equitable relief.” 665 F.2d 172, 175 (7th Cir. 1981). Section 1-23-630(A) of the South Carolina Administrative Procedures Act provides that an administrative law judge “has the same power at chambers or in open hearing as do circuit court judges and to issue those remedial writs as are necessary to give effect to its jurisdiction.” S.C.Code Ann. § 1-23-630(A) (2005). Article V. of the Constitution of the State of South Carolina provides at § 20 that:

Each of the Justices of the Supreme Court and judges of the Court of Appeals and Circuit Court and of all other courts of record shall have the same power at chambers to issue writs of habeas corpus, mandamus, quo warranto, certiorari, prohibition, and interlocutory writs or orders of injunction as when in open court. The judges of the Court of Appeals and Circuit Court and other courts of record shall have such additional powers at chambers as the General Assembly may provide, except in matters required to be determined in a public trial. (1985 Act No. 9, eff February 26, 1985.)

This Court has the power, pursuant to South Carolina Administrative Code § 18-9-270, to reverse, affirm, or modify the judgment or order below in whole or in part and as to any or all of the parties. Richard prays that this Court would exercise its power to rule that the establishment of caps on services and the amendment of the Medicaid waiver at issue in this case violated the South Carolina Administrative Procedures Act. The Court based its affirmation of the lower Court's decision that DHHS did not violate the SC APA in capping and terminating waiver services on *Arrowood II*, a case that was not mentioned in briefing by the Appellant, the Respondent or the Amici. That 2-1 decision did not involve the Medicaid Act, and its facts are clearly distinguishable from those in Richard's appeal. In *Arrowood I*, the North Carolina Court of Appeals ruled that the North Carolina Department of Health and Human Services violated the North Carolina Administrative Procedures Act by limiting AFDC benefits to 24 months, as allowed by the federal government. *Arrowood v. North Carolina Department of Health and Human Services*, 140 N.C.App. 31, 535 S.E.2d 585 (N.C.Ct.App. 2000) (Hereinafter referred to as "*Arrowood I*.") In *Arrowood I*, the plaintiff had signed a statement agreeing that his AFDC benefits would be limited and he agreed to a termination date for those benefits. *Id.* Subsequently, unlike the present case, the North Carolina General Assembly enacted a statute limiting those benefits to 24 months. *Id.* Despite the plaintiff having agreed in writing to the 24 month limitation, the North Carolina Court of Appeals ruled in *Arrowood I* that the limitation was unenforceable, because it had not been promulgated as a regulation under the NC APA at the time the plaintiff's benefit period began.

It is interesting to note that on the same day that the North Carolina Court of Appeals issued *Arrowood I*, it also issued a unanimous opinion in a case that did involve Medicaid

benefits, *Dillingham v. North Carolina Department of Human Resources*, 132 N.C. App. 704, 513 S.E.2d 823 (N.C.App. 1999). Judge Martin authored both the *Arrowood I* and the *Dillingham* decisions. Judge Lewis concurred with Judge Martin in *Arrowood I*, and Judge Walker dissented.

In *Dillingham*, the North Carolina Court of Appeals ruled that the changes set forth in the agency's Medicaid Manual were unenforceable, because they had not been promulgated "in accordance with the requirements of the Administrative Procedures Act." Id. at 825. The Court held that the Manual "must be construed as nothing more than incidental support for the decision..." Id. It ruled that the DHHS policy "creates a binding standard which interprets the eligibility provision of the medical law..." and that it was not "valid unless adopted in accordance with the provisions of Article 2A of the Administrative Procedure Act. N.C. Gen. Stat. § 150B-18."

Three months later, the North Carolina Court of Appeals issued another unanimous decision involving the Medicaid Act. In *Duke Medical Center v. Bruton*, that Court ruled that the DHHS Medicaid policy in question "was not a properly promulgated rule within the meaning of the North Carolina Administrative Procedure Act (NCAPA), G.S. § 150B-18, and was therefore not binding on the public." 134 N.C.App. 39, 41, 516 S.E.2d 633, 634 (N.C.App. 1999). The court ruled in *Duke* that the policy was not only "contrary to federal law," but that the action "constitutes an unpromulgated legislative rule such that enforcement amounts to an 'unlawful procedure' under the NCAPA." Id. at 637. The court concluded that the policy was "an administrative 'rule'" that "creates a binding standard which interprets the eligibility and coverage provisions of the Medicaid law and, in addition, denies a substantial right." Id. 641. As

such, the *Duke* court ruled the policy was an “unpromulgated legislative rule and amounts to an unlawful procedure...” Id. at 641. Judges Greene and Wynn (now on the Fourth Circuit Court of Appeals) agreed that the policy violated the NC APA.

In 2000, a year after *Dillingham* and *Duke* were decided, the North Carolina Supreme Court issued a one sentence *per curium* opinion in *Arrowood II* that adopted the dissenting opinion of Judge Walker in *Arrowood I*. *Arrowood II*, 353 N.C. 351, 543 S.E.2d 481 (N.C. 2001). In his dissent, Judge Walker noted that the plaintiff failed to petition DHHS to adopt the ADFC rule pursuant to the Administrative Procedures Act. He based the dissent, in part, on a North Carolina statute which prohibits the state from adopting a rule that “repeats the content of a law, a rule or a federal regulation.” *Arrowood I* at 593. Most importantly, Judge Walker recognized that “... an APA rule was necessary in *Dillingham*..” Id. at 593. Thus, he clearly distinguished the ADFC case from the decision involving the Medicaid Act in *Dillingham*.

More than a decade later, in *McCrann ex rel. McCrann v. Department of Health and Human Services*, any question about the need to promulgate changes in the State’s Medicaid program pursuant to the Administrative Procedures Act was put to rest. 704 S.E.2d 899 (N.C. 2011). In *McCrann*, as in Richard’s case, the State received approval from CMS for the amendments to the Medicaid waiver program in question.⁸ Id. 902. In a unanimous opinion, three different judges, who had not been involved in the *Arrowood* or the *Dillingham* decisions, distinguished the *Arrowood* case from the court’s holding in *Dillingham*:

Additionally, the *Arrowood I* dissent agreed with the holding in *Dillingham* that

⁸ CMS also approved the caps that were subsequently determined likely to violate the ADA in *Peter B. v. Sanford, Supra*, as well as the caps at issue in *Moore v. Cook*, 1:07-cv-631 (Ga.D.C. April 19, 2012).

promulgation of a rule under the APA was required in that case in order for the rule to be valid.

Id. at 906. The court ruled that:

We conclude that the present case is similar to the facts presented in *Dillingham* and we agree with petitioners that *Arrowood II* is not controlling.

Id. Like Richard, the Medicaid participant in *McCrann* had not signed a written agreement, as did the plaintiff in *Arrowood I*. The court emphasized in *McCrann* that the Medicaid participant's knowledge of the changes simply "cannot equate" with the "contractual agreement" that existed in *Arrowood I*. ("Mere knowledge of the potential for denial of services is quite distinct from an agreement to be bound by terms explicitly set forth in a written contract.") The Court of Appeals ruled that to extend the holding of *Arrowood II* to the facts of this Medicaid case would "enact fundamental changes in administrative law." Id. at 906.

That is exactly what would result if this Court should not reconsider its holding that allows DHHS to amend the Medicaid waiver without complying with the SC APA, or having the General Assembly enact a statute approving the changes. The unintended consequences of this ruling could be seismic and have far reaching unintended results across the State, thereby giving the Executive Branch unfettered power, in excess of that intended by the General Assembly of the State of South Carolina or the framers of the Constitution of the State of South Carolina. In *McCrann*, the court held that "Such a holding would be in stark contrast to the uniformity in this area of the law in jurisdictions across the United States." Id.

As recognized in *McCrann*, in *In re Deil*, the Vermont Supreme Court ruled that the provision by Vermont's Human Services Board that resulted in the denial of welfare benefits was invalid, because it had not been adopted as a regulation. 158 Vt. 549, 614 A.2d 1223 (1992). In that case, the Court held that:

The Legislature has authorized the Commissioner of the Department of Social Welfare to issue regulations necessary to administer the laws for which she is responsible. 33 V.S.A. § 105(c)(1), (2). It has not provided the Department an exemption from complying with the APA. Hence, the Commissioner must adopt rules in the manner prescribed by the APA. 3 V.S.A. § 831(a); see 3 V.S.A. §§ 836-843 (rulemaking procedures providing for publication, hearings, and legislative review). The APA does not exempt rules concerning benefits from its coverage. See 3 V.S.A. § 832 (exemptions from rulemaking).

Id. 1226. Further, the court found, in that case, that “As the Human Services Board noted, there would have been no conflict over the Department's calculation of income if it had followed the APA throughout the process.”⁹ Id. 1228.

The North Carolina Court of Appeals recognized in *McCrann* that:

...Arrowood II is an exception to the general principal that “[a]n administrative rule is not valid unless adopted in accordance with the provisions of Article 2A of the Administrative Procedure Act” and its holding is limited to the *unique facts of that case*. (Emphasis added.) Citing *Dillingham*, 132 N.C.App. At 710, 513 S.E.2d at 827; N.C. Gen. Stat. § 150B-18.

Id. at 907. The Court unambiguously held in *McCrann* that “*Arrowood* draws a clear line by which courts can recognize this exception - where the recipient of the benefits has contractually agreed to the terms of the waiver, obviating the need for further notice from promulgation of the

⁹ In *Smith v. Department of Human Services Director* the Michigan Court of Appeals ruled that:

An agency's failure to substantially comply with the procedural requirements for promulgating rules under the APA renders a rule invalid and precludes it from having the force of law. MCL 24.243; *Goins v. Greenfield Jeep Eagle, Inc.*, 449 Mich. 1, 9-10, 534 N.W.2d 467 (1995). Because the DHS's policy constitutes a rule, no exception to the rulemaking requirements of the APA applies, and the DHS failed to follow the procedures for promulgating rules, the circuit court correctly concluded that the rule is invalid to the extent that state funding is involved.

822 N.W.2d 616, 628, 297 Mich.App. 148 (Ct. App. 2012). After the State agency complied with the state's APA the parties settled this case. 828 N.W.2d 18 (Mich. 2013). DHHS could avoid continued litigation, which has resulted from its ongoing violations of the APA, by simply promulgating regulations that establish reasonable standards which are not arbitrary and capricious to be used in the review of Medicaid State Plan and waiver amendments.

rule in accordance with the APA.”¹⁰ In conclusion, the court held that “because the provision of the waiver at issue here was a rule that was not promulgated in accordance with the APA, and the circumstances presented do not fit within the *Arrowood II* exception, the provision is not legally binding and could not properly serve as the legal basis for DHHS’ denial of Jonathan’s benefits.” Id.

As did South Carolina, during 2010, the State of North Carolina reduced the service package provided by the Medicaid waiver program that serves persons with intellectual disabilities and related disabilities. But, those changes in North Carolina were enacted by the

¹⁰ Also, unlike the S.C. A.P.A., N.C.’s APA specifically exempts its State Medicaid Agency from the rule making requirements contained in the APA. N.C. Statutes §150B-1(d)(9). But, it requires the North Carolina Department of Health and Human Services to comply with another statute setting out the requirements the agency must follow prior to changing its policies. Chapter § 108A-54.2 establishes the requirements DHHS must follow before changing its “medical coverage policy,” which is defined as “those policies, definitions, or guidelines utilized to evaluate, treat, or support the health or developmental conditions of a recipient so as to determine eligibility, authorization or continued authorization, medical necessity, course of treatment and supports, clinical outcomes, and clinical supports treatment practices for a covered procedure, product or service.” At least 45 days prior to adopting a new policy or amending existing coverage, the North Carolina General Assembly requires the agency to provide specific notice to providers and participants. In some cases a shorter period may be allowed.

Importantly, unless directed by the North Carolina General Assembly to change medical policy that affects the amount, sufficiency, duration and scope of health care services and who may provide services, the Division of Medical Assistance must prepare a five-year fiscal analysis before making changes. The agency must submit any changes in medical policy costing in excess of \$500,000 to (or \$50,000 for NC Health Choice in any given fiscal year) to the Office of State Budget and Management and Fiscal Research Division. That Office must identify and approve the source of funding for any such change. By November 1 of each fiscal year, DHHS must report “all medical policy changes with total requirements” less than \$500,000 to the Office of State Budget and Management and the Fiscal Research Division of the Legislative Services Commission. In Richard’s case, DHHS and DDSN made changes to a program that, by their own records cost South Carolina taxpayers tens of millions of dollars a year. The average cost per participant increased by more than \$8,000 a year when the caps were put into place and other services were eliminated from the waiver program

North Carolina General Assembly, unlike the changes at issue in *Stogsdill v. DHHS*, which were announced after the adjournment of the South Carolina General Assembly, and went into effect just prior to the beginning of the 2010 Session. *Pashby v. Cansler*, 709 F.3d 307 (4th Cir. 2023).

But, even though approved by the North Carolina General Assembly, the Fourth Circuit held the reductions made by North Carolina DHHS violated of the Americans with Disabilities Act. *Id.* As this Court noted, the Fourth Circuit held in that case that:

...[s]tate budgetary concerns cannot ... be ‘the conclusive factor in decisions regarding Medicaid,’ " *id.* (quoting *Ark. Med. Soc’y v. Reynolds*, 6 F.3d 519, 531 (8th Cir.1993)). *Pashby* at 330. And, as the Fourth Circuit held in *Pashby*: "...the public interest always lies with upholding the law and having the mandates of the Medicaid Act, the ADA, the Rehabilitation Act, and due process enforced." *Id.* at 356.

Conclusion

Richard is a young man who has demonstrated that he has been prejudiced by being subjected to five years of state administrative appeals, without certainty, all this time, that he will be able to remain in his own home. His non-disabled friends from high school are finishing collegiate studies, getting married and starting families. He asks in this administrative action to be provided with the supports he needs to live at home, where he has lived since he was a young child, and to participate in the community. When Richard filed an administrative appeal in 2009, DDSN responded as they did in DHHS, attempting to reduce his Medicaid waiver services even further while he had an ongoing appeal. This is a violation of the Medicaid Act for the reasons set forth in *B.W. v. DHHS*, Exhibits 4, 5 and 6.

The South Carolina Legislative Audit Council documented that DDSN spent tens of millions of dollars (perhaps more) building up and buying segregated workshops with funds the General Assembly intended to be used, instead, to provide home-based services in the

community to people like Richard. R. 720 to 722. While other States were closing down segregated workshops, DDSN was wildly spending money, without authorization from the General Assembly, planning to send more persons who have disabilities, like Richard, to work in these warehouses. This Court may take judicial notice of the report issued by the National Protection & Advocacy System at <http://www.ndrn.org/images/Documents/Resources/Publications/Reports/Segregated-and-Exploited.pdf>, which describes the isolation and discrimination experienced in these twentieth-century “workhouses.” By reducing the number of hours of services provided at home, the agencies knew that more waiver participants would be likely to “choose” this option. They had no other “choice” when the hours they received at home were cut.

The LAC Audit reported that DDSN spent just \$7.6 million out of the \$25.4 million allocated by the General Assembly to operate new beds in the community for the intended purpose. R. 720. When the agency did not spend the money as allocated, it lost the 70% matching funds. Id. But DDSN officials told the LAC auditors that they “spent all of the funds appropriated for items related to the new beds.” R. 722. Much of this money appears to have been spent on “day programs” and “other administrative functions” - including segregated workshop buildings across the State. Id. Some of this money was given to private corporations, some to local DSN Boards, without rhyme or reason, or any authorization by the Legislative Branch of Government. R. 722. This happened because there are no regulations requiring DDSN and DHHS to notify the public and the General Assembly before diverting millions of dollars for unintended purposes.

The 2008 LAC Audit of DDSN documented that the agency spent just \$10,454 out of the \$3 million in state dollars allocated to provide services for children with autism in FY 06 through

the “PDD” program (a Medicaid waiver program for young children who have autism). R. 723. The following year, in FY 07, the General Assembly allocated \$7.5 million more, specifically to provide these PDD services, but that year, only \$661,463 was used for the intended purpose. *Id.* Those lucky enough to enroll in the program received an average of \$15,000 per annum in services, while DDSN had been budgeted to provide \$37,000 of services per annum per PDD waiver participant. *Id.* Had there been regulations requiring DDSN and DHHS to notify the General Assembly and the public when these funds were used for different purposes, the result might have been different.

Allowing the agencies to alter Medicaid waiver programs without legislative oversight or regulations is a recipe for even more costly disasters in the future - costly financially, but far more important is the human costs, like those paid by Richard and his family, which are immeasurable. Richard prays that this Court will reconsider its decision regarding DHHS’ obligation to promulgate regulations so as to comply with the S.C. A.P.A.

For the reasons set forth in the attached Motion for Summary Judgment filed with the federal district court, this Court may consider and rule upon the other violations of the *Olmstead* mandate, and issue an order requiring DHHS to give the greatest deference to Richard’s treating physician and considering the violations of the Medicaid Act, or to inform the parties that this Court will not rule on those issues.

The opinions of Richard’s physician have clearly been given absolutely no deference in this case, in clear violation of *Olmstead*. DDSN employees who testified at Richard’s second hearing admitted that they had not even reviewed his medical records or spoken with his doctor. Richard he has not received the services he requested in 2009, which were ordered by his

physician, and has not received even a final, appealable “fair hearing” decision on that request. More than five years ago, the DHHS hearing officer ruled that his need for services must be determined by “qualified” persons. It is true that DDSN did not reduce the hours he was receiving in Dec. 2009 - but it’s taken five years to obtain judicial review of the decision to further reduce his services, even below the amount he was receiving when he asked DHHS for a fair hearing. DHHS attempted, during the 2009 appeal, to reduce his services below the amount, duration and scope of services he needs to remain in the home.

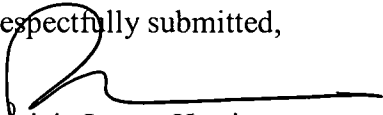
The Fourth Circuit has twice instructed DHHS and DDSN that Respite does not equal Res Hab (*Doe v. Kidd I and II, supra*), nor can those services be adequately substituted for Personal Care services. DHHS has not only attempted to reduce Richard’s Personal Care hours, replacing them with “Respite” hours, but it has ignored the holding of *Doe v. Kidd I and II* by attempting to provide lesser services “on the cheap.”

The DHHS Medical Care Advisory Committee adopted waiver amendments on Aug. 18, 2009, after the General Assembly adjourned for the year. R. 821. The changes went into effect on January 1, 2010, before the General Assembly reconvened. Due to ARRA, the federal match rate went from 70% to 79% in February, 2009. These changes were effective in Feb. 2009 - thus DDSN and DHHS was required to use significantly less in state dollars than had been appropriated for FY 2009 to pay for Medicaid services. DDSN minutes from April 16, 2009 show that DDSN would receive an additional \$28.8 million during FY 2009 due to ARRA. Yet, DDSN Deputy Director Kathi Lacy reported that “It was decided to cap some services that are most used by *people living at home* with their families...” R. 851. DHHS official Sam Waldrep said that the services being removed were those with “low utilization.” These numbers and

justifications for the waiver amendments their explanations simply do not add up. The rationale used by agency officials could not be more arbitrary and capricious.

It is reasonable, just and fair to provide Richard the services he needs to remain at home while DHHS and DDSN figure out how to comply with the SC APA. These agencies should have done that years ago, when P&A filed a lawsuit, simply asking DDSN to promulgate regulations. (*Protection & Advocacy et. al. v. DDSN*, Circuit Court Case No. 07-cp-40-2817, S.C. Court of Appeals Case No. 2014-000244). This Court was correct when it determined that the State has failed to demonstrate that it would cause a fundamental alteration in the system to provide Richard the services he needs. Indeed, the light Richard has shed on this program may serve the important public purpose of saving taxpayers of millions of dollars and preventing the institutionalization of persons, like him, who just want to live peacefully in their homes.

Respectfully submitted,



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September 25, 2014

Corrected September 30, 2014

Exhibit 1

DOCKET: Richard Stogsdill et al v. Sebelius et al
3:12-cv-00007-JFA

JURY,LC 1

**U.S. District Court
District of South Carolina (Columbia)
CIVIL DOCKET FOR CASE #: 3:12-cv-00007-JFA**

Richard Stogsdill et al v. Sebelius et al
Assigned to: Honorable Joseph F Anderson, Jr
Cause: 42:12117 Americans with Disabilities Act

Date Filed: 01/01/2012
Jury Demand: Both
Nature of Suit: 446 Civil Rights: Americans
with Disabilities - Other
Jurisdiction: Federal Question

Date Filed	#	Docket Text
01/01/2012	<u>1</u>	COMPLAINT against CMS, John Doe 1 through 20, Anthony Keck, Cynthia Mann, Kathleen Sebelius, South Carolina Department of Health and Human Services (Filing fee \$ 350 receipt number 0420-387506.), filed by Nancy S, Mary S, Richard S, Rob L.(gpre,) Modified on 1/4/2012 to replace document with corrected signature as provided by filing user (gpre,). (Entered: 01/03/2012)
01/01/2012	<u>2</u>	Local Rule 26.01 Answers to Interrogatories by Mary S, Nancy S, Richard S, Rob L. (gpre,) Modified on 1/4/2012 to edit text(gpre,). (Entered: 01/03/2012)
01/12/2012	<u>5</u>	Summons Issued as to CMS, John Doe 1 through 20, Anthony Keck, Cynthia Mann, Kathleen Sebelius, South Carolina Department of Health and Human Services. (gpre,) (Entered: 01/12/2012)
03/20/2012	<u>6</u>	MOTION to Dismiss for Lack of Jurisdiction by Anthony Keck, South Carolina Department of Health and Human Services. Response to Motion due by 4/6/2012 (Attachments: # <u>1</u> Memo in Support)No proposed order(Wlodarczyk, Damon) (Entered: 03/20/2012)
03/20/2012	<u>7</u>	Local Rule 26.01 Answers to Interrogatories by Anthony Keck, South Carolina Department of Health and Human Services.(Wlodarczyk, Damon) (Entered: 03/20/2012)
04/06/2012	<u>9</u>	RESPONSE in Opposition re <u>6</u> MOTION to Dismiss for Lack of Jurisdiction Response filed by Mary S, Nancy S, Richard S, Rob L.Reply to Response to Motion due by 4/16/2012 (Attachments: # <u>1</u> Exhibit Final Administrative Order in the Appeal Matter of R.S. v. SCDHHS)(Harrison, Patricia) (Entered: 04/06/2012)
04/24/2012	<u>10</u>	LETTER EXTENDING TIME TO ANSWER John Doe 1 through 20 answer due 5/22/2012; Kathleen Sebelius answer due 5/22/2012; CMS answer due 5/22/2012; Cynthia Mann answer due 5/22/2012. (Newman, Christie) Modified on 4/26/2012 to replace with corrected document as provided by filing user (gpre,). (Entered: 04/24/2012)
05/18/2012	<u>12</u>	MOTION for Extension of Time to File Answer re <u>1</u> Complaint, by CMS, Cynthia Mann, Kathleen Sebelius. Response to Motion due by 6/4/2012 No proposed order(Newman, Christie) (Entered: 05/18/2012)
05/21/2012	<u>13</u>	TEXT ORDER granting <u>12</u> Motion for Extension of Time to Answer re <u>1</u> Complaint, CMS answer due 6/5/2012; Cynthia Mann answer due 6/5/2012; Kathleen Sebelius answer due 6/5/2012. Signed by Honorable Timothy M Cain on 5/21/12.(gpre,) (Entered: 05/21/2012)
05/25/2012	<u>14</u>	ORDER denying <u>6</u> Motion to Dismiss for Lack of Jurisdiction. Plaintiffs shall file an amended complaint within 10 days of this order in compliance with this order. Signed by Honorable Timothy M Cain on 5/25/12.(gpre,) (Entered: 05/25/2012)
06/04/2012	<u>16</u>	AMENDED COMPLAINT <i>First Amended Complaint</i> against All Defendants, filed by

		Nancy S, Mary S, Richard S, Rob L. (Harrison, Patricia) (Entered: 06/04/2012)
06/14/2012	<u>17</u>	NOTICE of Request for Protection from Court Appearance by Patricia L Harrison for June 25,2012-July 10, 2012 (Harrison, Patricia) Modified on 6/15/2012 to edit text (alew,). (Main Document 17 replaced on 6/15/2012) (alew,). Modified on 6/15/2012 to replace with corrected document provided by filing user(alew,). (Entered: 06/14/2012)
06/18/2012	<u>18</u>	MOTION TO DISMISS FOR FAILURE TO STATE A CLAIM , MOTION to Dismiss for Lack of Jurisdiction (Response to Motion due by 7/5/2012) by CMS, Cynthia Mann, Kathleen Sebelius. No proposed order(Newman, Christie) (Entered: 06/18/2012)
06/19/2012	<u>19</u>	First MOTION for Extension of Time by John Doe 1 through 20, Mary S, Nancy S, Richard S, Rob L. Response to Motion due by 7/6/2012 No proposed order(Harrison, Patricia) (Entered: 06/19/2012)
06/19/2012	<u>20</u>	TEXT ORDER granting <u>19</u> Motion for Extension of Time. Plaintiff shall have until July 26, 2012, to file a response to Federal Defendants Motion to Dismiss. Signed by Honorable Timothy M. Cain on 6/19/2012.(vmcd) (Entered: 06/19/2012)
06/25/2012	<u>21</u>	ANSWER to <u>16</u> Amended Complaint by Anthony Keck, South Carolina Department of Health and Human Services.(Wlodarczyk, Damon) (Entered: 06/25/2012)
06/26/2012	<u>22</u>	CONFERENCE AND SCHEDULING ORDER Rule 26(f) Conference Deadline 7/16/2012, 26(a) Initial Disclosures due by 7/30/2012, Rule 26 Report due by 7/30/2012, Motions to Amend Pleadings due by 9/10/2012, Plaintiffs ID of Expert Witness due by 10/31/2012, Defendants ID of Expert Witnesses Due by 11/9/2012, Records Custodian Affidavit due by 11/9/2012, Discovery due by 12/10/2012, Motions due by 12/27/2012, Rule 26(a)(3) Disclosures due by 3/1/2013, Jury Selection Deadline 4/2/2013, Signed by Honorable Timothy M Cain on 6/26/12. (gpre,) (Entered: 06/26/2012)
07/14/2012	<u>23</u>	MOTION for Extension of Time of Rule 26(f) Conference to July 25, 2012, by Anthony Keck, South Carolina Department of Health and Human Services. Response to Motion due by 8/2/2012 No proposed order(Wlodarczyk, Damon) (Entered: 07/14/2012)
07/14/2012	<u>24</u>	Amended MOTION for Extension of Time of Rule 26(f) Conference to July 25, 2012, by Anthony Keck, South Carolina Department of Health and Human Services. Response to Motion due by 8/2/2012 No proposed order(Wlodarczyk, Damon) (Entered: 07/14/2012)
07/16/2012	<u>25</u>	TEXT ORDER granting <u>24</u> Motion for Extension of Time. The Fed. R. Civ. P. 26(f) conference deadline is extended to July 25, 2012. Signed by Honorable Timothy M. Cain on 7/16/2012.(vmcd) (Entered: 07/16/2012)
07/16/2012	<u>26</u>	ORDER finding as moot <u>23</u> Motion for Extension of Time. Signed by Honorable Timothy M. Cain on 7/16/2012.(vmcd) (Entered: 07/16/2012)
07/18/2012	<u>27</u>	MEDIATION ORDER, Mediation Due by 12/17/2012, Signed by Honorable Timothy M Cain on 7/18/2012. (gpre,) (Entered: 07/18/2012)
07/26/2012	<u>28</u>	RESPONSE in Opposition re <u>18</u> MOTION TO DISMISS FOR FAILURE TO STATE A CLAIM MOTION to Dismiss for Lack of Jurisdiction Response filed by Mary S, Nancy S, Richard S, Rob L.Reply to Response to Motion due by 8/6/2012 (Harrison, Patricia) (Entered: 07/26/2012)
07/30/2012	<u>29</u>	REPLY by CMS, Cynthia Mann, Kathleen Sebelius to <u>27</u> Mediation Order . (Newman, Christie) (Entered: 07/30/2012)
08/06/2012	<u>32</u>	REPLY to Response to Motion re <u>18</u> MOTION TO DISMISS FOR FAILURE TO STATE A CLAIM MOTION to Dismiss for Lack of Jurisdiction Response filed by CMS, John Doe 1 through 20, Cynthia Mann, Kathleen Sebelius. (Attachments: # <u>1</u> Unpublished opinion, Kinetic Concepts, Inc. v. Convatec, Inc.)(Newman, Christie) (Entered: 08/06/2012)

08/08/2012	<u>34</u>	MOTION for Extension of Time by Robert Levin, Mary S, Nancy S, Richard S, Rob L, Mary Self, Nancy Stogsdill, Richard Stogsdill. Response to Motion due by 8/27/2012. No proposed order.(Harrison, Patricia) (Entered: 08/08/2012)
08/27/2012	<u>35</u>	REPLY by CMS, John Doe 1 through 20, Cynthia Mann, Kathleen Sebelius to <u>34</u> MOTION for Extension of Time . (Newman, Christie) (Entered: 08/27/2012)
08/27/2012	36	TEXT ORDER granting <u>34</u> Motion for Extension of Time. Signed by Honorable Timothy M. Cain on 8/27/2012.(vmcd) (Entered: 08/27/2012)
11/01/2012	<u>37</u>	MOTION for Extension of Time by Robert Levin, Mary S, Nancy S, Richard S, Rob L, Mary Self, Nancy Stogsdill, Richard Stogsdill. Response to Motion due by 11/19/2012. No proposed order.(Harrison, Patricia) (Entered: 11/01/2012)
11/05/2012	38	TEXT ORDER granting <u>37</u> Motion for Extension of Time. Signed by Honorable Timothy M Cain on 11/5/2012.(gpre,) (Entered: 11/05/2012)
11/05/2012	<u>39</u>	SCHEDULING ORDER Plaintiffs ID of Expert Witness due by 11/30/2012, Defendants ID of Expert Witnesses Due by 12/30/2012, Discovery due by 2/15/2013, Motions due by 3/1/2013, Signed by Honorable Timothy M Cain on 11/5/2012. (gpre,) (Entered: 11/05/2012)
12/13/2012	<u>40</u>	Joint MOTION to Stay re <u>27</u> Mediation Order, <u>39</u> Scheduling Order, and <i>Mediation Order</i> by CMS, Anthony Keck, Cynthia Mann, Kathleen Sebelius, South Carolina Department of Health and Human Services. Response to Motion due by 1/2/2013. Proposed order is being emailed to chambers with copy to opposing counsel.(Wlodarczyk, Damon) (Entered: 12/13/2012)
01/14/2013	41	TEXT ORDER granting <u>40</u> Motion to Stay. The deadlines set forth in the current Scheduling Order (Dkt. # 39) and Mediation Order (Dkt. # 27) are stayed pending the resolution of the Defendants' Motion to Dismiss (Dkt. # 18). Signed by Honorable Timothy M. Cain on 1/14/2013.(vmcd) (Entered: 01/14/2013)
02/11/2013	<u>42</u>	ORDER granting <u>18</u> Motion to Dismiss for Lack of Jurisdiction; denying alternative Motion to Dismiss for Failure to State a Claim. Signed by Honorable Timothy M Cain on 2/11/2013.(gpre,) (Entered: 02/11/2013)
02/11/2013	44	TEXT ORDER. The parties shall submit a joint amended scheduling order by February 25, 2013. Signed by Honorable Timothy M. Cain on 2/11/2013. (vmcd) (Entered: 02/11/2013)
03/13/2013	<u>47</u>	CONSENT FIRST AMENDED SCHEDULING ORDER Motions to Amend Pleadings due by 9/10/2013, Plaintiffs ID of Expert Witness due by 9/30/2013, Defendants ID of Expert Witnesses Due by 10/14/2013, Records Custodian Affidavit due by 11/11/2013, Discovery due by 10/28/2013, Motions due by 11/11/2013, Rule 26 (a)(3) Disclosures due by 12/16/2013, Jury Selection Deadline 1/10/2014, Mediation Due by 11/1/2013, Signed by Honorable Timothy M Cain on 3/13/2013. (gpre,) (Entered: 03/13/2013)
03/21/2013	<u>48</u>	NOTICE of Request for Protection from Court Appearance by Patricia L Harrison for April 10, 2013 to April 22, 2013 (Harrison, Patricia) (Entered: 03/21/2013)
06/27/2013	<u>49</u>	NOTICE of Request for Protection from Court Appearance by Patricia L Harrison for July 8, 2013 to July 17, 2013 (Harrison, Patricia) (Entered: 06/27/2013)
09/06/2013	<u>50</u>	MOTION for Extension of Time to <i>File Motion to Join or Amend</i> by Mary S, Nancy S, Richard S, Rob L. Response to Motion due by 9/23/2013. No proposed order.(Harrison, Patricia) (Entered: 09/06/2013)
09/09/2013	51	TEXT ORDER granting <u>50</u> Consent Motion for Extension of Time. Plaintiffs shall have until September 30, 2013, to file a motion to join other parties or amend the pleadings. Signed by Honorable Timothy M. Cain on 9/9/2013.(vmcd) (Entered: 09/09/2013)

09/27/2013	<u>52</u>	MOTION for Extension of Time by Mary S, Nancy S, Richard S, Rob L. Response to Motion due by 10/15/2013. No proposed order.(Harrison, Patricia) (Entered: 09/27/2013)
10/01/2013	54	DELETION OF DOCKET ENTRY NUMBER 53 Reason: Proposed orders should not be filed as Supplements. (gpre,) (Entered: 10/01/2013)
10/01/2013	<u>55</u>	MOTION to Amend/Correct <i>Joint Motion for Amendment to Scheduling Order</i> by Robert Levin, Mary Self, Nancy Stogsdill, Richard Stogsdill. Response to Motion due by 10/18/2013. Proposed order is being emailed to chambers with copy to opposing counsel. (Harrison, Patricia) (Entered: 10/01/2013)
10/02/2013	56	TEXT ORDER finding as moot <u>52</u> Motion for Extension of Time; granting <u>55</u> Motion to Amend Scheduling Order. Signed by Honorable Timothy M Cain on 10/2/2013.(gpre,) (Entered: 10/02/2013)
10/02/2013	<u>57</u>	CONSENT SECOND SCHEDULING ORDER Motions to Amend Pleadings due by 10/4/2013, Plaintiffs ID of Expert Witness due by 10/30/2013, Defendants ID of Expert Witnesses Due by 11/29/2013, Records Custodian Affidavit due by 11/11/2013, Discovery due by 1/15/2014, Motions due by 2/14/2014, Rule 26(a)(3) Disclosures due by 2/28/2014, Jury Selection Deadline 3/14/2014, Mediation Due by 1/30/2014, Signed by Honorable Timothy M Cain on 10/2/2013. (gpre,) (Entered: 10/02/2013)
10/04/2013	<u>58</u>	MOTION to Amend/Correct <i>Motion to File Second Amended Complaint</i> by Robert Levin, Mary S, Nancy S, Richard S. Response to Motion due by 10/21/2013. (Attachments: # <u>1</u> Main Document Proposed Second Amended Complaint, # <u>2</u> Exhibit Exhibit 1. HHS Hearing Order June 29, 2009, # <u>3</u> Exhibit Exhibit 2. Worker's Compensation Case, # <u>4</u> Exhibit Exhibit 3. ALC Order dated March 13, 2013)No proposed order.(Harrison, Patricia) (Entered: 10/04/2013)
10/07/2013	59	TEXT ORDER denying <u>58</u> Motion to Amend/Correct. Plaintiffs have filed a motion to amend their complaint. (ECF No. 58). Plaintiffs attached a 46-page proposed amended complaint and 101 pages of exhibits. However, Plaintiffs failed to follow Local Civil Rules 7.02 and 7.04 DSC. It appears that while Plaintiffs consulted with opposing counsel on some amendments, Plaintiffs stated that they believed consultation on other specific amendments would serve no useful purpose. Local Rule 7.02, however, requires consultation, except in limited circumstances, none of which appear applicable here. Moreover, Plaintiffs motion does not comply with Local Rule 7.04, which requires a supporting memorandum. Local Rule 7.05 sets forth specific requirements which are to be included in the memorandum. In particular, the memorandum must contain a concise summary, concise statement of the facts, and argument relating to the matter before the court. Plaintiffs motion does not comply with the Local Rules. Accordingly, Plaintiffs Motion to Amend (ECF No. 58) is DENIED with leave to re-file a motion which complies with the Local Rules. Signed by Honorable Timothy M. Cain on 10/7/2013.(vmcd) (Entered: 10/07/2013)
10/08/2013	60	TEXT ORDER. Plaintiffs shall have until October 15, 2013, to file a motion to amend their complaint. Signed by Honorable Timothy M. Cain on 10/8/2013. (vmcd) (Entered: 10/08/2013)
10/15/2013	<u>61</u>	MOTION to Amend/Correct by Robert Levin, Mary Self, Nancy Stogsdill, Richard Stogsdill. Response to Motion due by 11/1/2013. (Attachments: # <u>1</u> Memo in Support Memorandum in Support of Motion to Amend, # <u>2</u> Exhibit Revised Proposed Second Amended Complaint, # <u>3</u> Exhibit Richard Stogsdill v. DHHS, DHHS decision June 29, 2009, # <u>4</u> Exhibit Buhrman v. Self, Workers Compensation Decision, # <u>5</u> Exhibit Richard Stogsdill v. DHHS, SC ALC Decision March 13, 2013, # <u>6</u> Exhibit SC ALC Accountability Report, # <u>7</u> Exhibit Respite Worker v. Kershaw County DSN Board, October 25, 2011)No proposed order.(Harrison, Patricia) Modified on 11/1/2013 to edit text (gpre,). (Entered: 10/15/2013)
10/21/2013	<u>62</u>	NOTICE of Request for Protection from Court Appearance by Patricia L Harrison for

		October 28 - November 8, 2013 (Harrison, Patricia). Modified on 10/30/2013 to replace corrected document as provided by filing user (gpre,). (Entered: 10/21/2013)
10/25/2013	<u>63</u>	MOTION for Extension of Time <i>for Providing Written Expert Reports by Plaintiffs</i> by Robert Levin, Mary Self, Nancy Stogsdill, Richard Stogsdill. Response to Motion due by 11/12/2013. No proposed order.(Harrison, Patricia) (Entered: 10/25/2013)
10/28/2013	64	TEXT ORDER granting 63 Consent Motion for Extension of Time. The court's previous scheduling order (ECF No.57) is amended so as to provide that Plaintiffs shall have until November 8, 2013, to identify their experts, and Defendants shall shall until December 13, 2013, to identify their experts. Signed by Honorable Timothy M. Cain on 10/28/2013.(vmcd) (Entered: 10/28/2013)
10/31/2013	<u>65</u>	RESPONSE in Opposition re <u>61</u> MOTION to Amend/Correct Response filed by Anthony Keck, South Carolina Department of Health and Human Services.Reply to Response to Motion due by 11/12/2013 (Attachments: # <u>1</u> Exhibit A - E-mail communication between counsel)(Wlodarczyk, Damon) (Entered: 10/31/2013)
11/12/2013	<u>67</u>	REPLY to Response to Motion re <u>61</u> MOTION to Amend/Correct <i>Corrected Reply</i> Response filed by Robert Levin, Mary Self, Nancy Stogsdill, Richard Stogsdill. (Attachments: # <u>1</u> Exhibit Emails between Defendants' and Plaintiffs' Counsel, # <u>2</u> Exhibit 2008 LAC Review of DDSN)(Harrison, Patricia) (Entered: 11/12/2013)
11/13/2013	68	DELETION OF DOCKET ENTRY NUMBER 66 Reason: Refiled corrected document and attachments by filing user. Corrected Filing Document Number <u>67</u> File same date as original filing: 11/12/2013 (gpre,) (Entered: 11/13/2013)
12/02/2013	<u>69</u>	NOTICE of Request for Protection from Court Appearance by Patricia L Harrison for December 18 - 28, 2013 (Harrison, Patricia) (Entered: 12/02/2013)
12/17/2013	<u>70</u>	ORDER granting in part and denying in part 61 Motion to Amend Complaint.Plaintiffs shall have fifteen (15) days to file an amended second complaint. Amended Second Complaint due by January 2, 2014. Signed by Honorable Timothy M Cain on 12/17/2013.(gpre,) Modified on 12/17/2013 to edit text (gpre,). (Entered: 12/17/2013)
01/02/2014	<u>72</u>	AMENDED COMPLAINT <i>Second Amended Complaint</i> against Anthony Keck, South Carolina Department of Health and Human Services, filed by Richard Stogsdill, Mary Self, Nancy Stogsdill, Robert Levin. Service due by 5/5/2014 (Attachments: # <u>1</u> Exhibit Richard Stogsdill v. DHHS, DHHS decision dated June 29, 2009, # <u>2</u> Exhibit Buhrman v. Self, Worker's Compensation Decision, # <u>3</u> Exhibit Richard Stogsdill v. DHHS, Administrative Law Court March 13, 2013, # <u>4</u> Exhibit South Carolina Administrative Law Court Accountability Report, # <u>5</u> Exhibit Respite Worker v. Kershaw County DSN Board, October 25, 2011) (Harrison, Patricia) (Entered: 01/02/2014)
01/06/2014	<u>73</u>	Consent MOTION to Amend/Correct <u>57</u> Scheduling Order, by Anthony Keck, South Carolina Department of Health and Human Services. Response to Motion due by 1/24/2014. Proposed order is being emailed to chambers with copy to opposing counsel. (Wlodarczyk, Damon) (Entered: 01/06/2014)
01/07/2014	74	TEXT ORDER granting 73 Motion to Amend/Correct. Signed by Honorable Timothy M Cain on 1/7/2014.(gpre,) (Entered: 01/07/2014)
01/07/2014	<u>75</u>	CONSENT THIRD AMENDED SCHEDULING ORDER Discovery due by 3/3/2014, Motions due by 4/3/2014, Rule 26(a)(3) Disclosures due by 4/28/2014, Jury Selection Deadline 5/14/2014, Mediation Due by 3/18/2014, Signed by Honorable Timothy M Cain on 1/7/2014. (gpre,) (Entered: 01/07/2014)
01/17/2014	<u>76</u>	MOTION for Extension of Time to File Answer re <u>72</u> Amended Complaint,, by Anthony Keck, South Carolina Department of Health and Human Services. Response to Motion due by 2/3/2014. No proposed order.(Wlodarczyk, Damon) (Entered: 01/17/2014)
01/17/2014	<u>77</u>	ANSWER to <u>72</u> Amended Complaint,, by Anthony Keck, South Carolina Department of

		Health and Human Services.(Wlodarczyk, Damon) (Entered: 01/17/2014)
02/20/2014	<u>78</u>	TEXT ORDER granting <u>76</u> Motion for Extension of Time to Answer. Anthony Keck answer due 1/17/2014; South Carolina Department of Health and Human Services answer due 1/17/2014. Signed by Honorable Timothy M Cain on 2/20/2014.(gpre,) (Entered: 02/20/2014)
04/01/2014	<u>79</u>	Consent MOTION to Amend/Correct <u>75</u> Scheduling Order, by Anthony Keck, Robert Levin, Mary Self, South Carolina Department of Health and Human Services, Nancy Stogsdill, Richard Stogsdill. Response to Motion due by 4/18/2014. Proposed order is being emailed to chambers with copy to opposing counsel.(Wlodarczyk, Damon) (Entered: 04/01/2014)
04/02/2014	<u>80</u>	TEXT ORDER granting <u>79</u> Motion to Amend Scheduling Order. Signed by Honorable Timothy M Cain on 4/2/2014.(gpre,) (Entered: 04/02/2014)
04/02/2014	<u>81</u>	CONSENT FOURTH AMENDED SCHEDULING ORDER Discovery due by 5/16/2014, Motions due by 6/16/2014, Mediation Due by 5/30/2014, Signed by Honorable Timothy M Cain on 4/2/2014. (gpre,) (Entered: 04/02/2014)
05/16/2014	<u>83</u>	MOTION for Protective Order by Anthony Keck, South Carolina Department of Health and Human Services. Response to Motion due by 6/2/2014. No proposed order. (Wlodarczyk, Damon) (Entered: 05/16/2014)
06/02/2014	<u>85</u>	Case Reassigned to Judge Honorable Joseph F Anderson, Jr. Judge Honorable Timothy M Cain no longer assigned to the case. (glev,) (Entered: 06/02/2014)
06/02/2014	<u>86</u>	RESPONSE in Opposition re <u>83</u> MOTION for Protective Order <i>for Anthony Keck</i> Response filed by Robert Levin, Mary Self, Nancy Stogsdill, Richard Stogsdill.Reply to Response to Motion due by 6/12/2014 (Attachments: # <u>1</u> Exhibit Myers v. SCDHHS: SC ALC Order dtd Feb. 3, 2014, # <u>2</u> Exhibit Waddle v. SCDHHS: Administrative Decision dtd Nov. 19, 2013)(Harrison, Patricia) (Entered: 06/02/2014)
06/12/2014	<u>89</u>	REPLY to Response to Motion re <u>83</u> MOTION for Protective Order Response filed by Anthony Keck, South Carolina Department of Health and Human Services. (Attachments: # <u>1</u> Exhibit 1 - Depositio Excerpts of Kara Lewis, # <u>2</u> Exhibit 2 - Deposition Excerpts of Dr. Burton)(Wlodarczyk, Damon) (Entered: 06/12/2014)
06/16/2014	<u>91</u>	MOTION for Extension of Time <i>Consent Motion</i> by Robert Levin, Mary Self, Nancy Stogsdill, Richard Stogsdill. Response to Motion due by 7/3/2014. No proposed order. (Harrison, Patricia) (Entered: 06/16/2014)
06/18/2014	<u>92</u>	FIFTH AND FINAL SCHEDULING ORDER granting <u>91</u> MOTION for Extension of Time <i>Consent Motion</i>: Discovery due by 7/2/2014, Motions due by 7/16/2014, Jury Selection Deadline 11/5/2014. Signed by Honorable Joseph F. Anderson, Jr. on 06/17/2014. (bshr,) (Entered: 06/18/2014)
06/20/2014	<u>93</u>	ORDER denying <u>83</u> Motion for Protective Order. Signed by Honorable Joseph F. Anderson, Jr. on 06/20/2014.(bshr,) (Entered: 06/20/2014)
06/26/2014	<u>94</u>	MOTION to Take Deposition from Dr. Burton <i>by Telephone</i> by Anthony Keck, South Carolina Department of Health and Human Services. Response to Motion due by 7/14/2014. (Attachments: # <u>1</u> Exhibit 1 - Dr. Purton Deposition Excerpt, # <u>2</u> Exhibit 2 - E-mail regarding deposition time limit)Proposed order is being emailed to chambers with copy to opposing counsel.(Wlodarczyk, Damon) (Entered: 06/26/2014)
06/26/2014	<u>96</u>	TEXT ORDER granting <u>94</u> MOTION to Take Deposition from Dr. Marion Burton <i>by Telephone</i>. Entered at the direction of the Honorable Joseph F. Anderson, Jr. on 06/26/2014.(bshr,) (Entered: 06/26/2014)
07/11/2014	<u>97</u>	MOTION for Extension of Time <i>to File Dispositive Motions</i> by Robert Levin, Nancy S, Richard S. Response to Motion due by 7/28/2014. No proposed order.(Harrison, Patricia) (Entered: 07/11/2014)

07/14/2014	98	TEXT ORDER granting <u>97</u> Joint Motion for Extension of Time to File Dispositive Motions, extending deadline to 07/30/2014. Entered at the direction of the Honorable Joseph F. Anderson, Jr. on 07/14/2014.(bshr,) (Entered: 07/14/2014)
07/30/2014	<u>102</u>	MOTION for Summary Judgment by Anthony Keck, South Carolina Department of Health and Human Services. Response to Motion due by 8/18/2014. (Attachments: # <u>1</u> Memo in Support, # <u>2</u> Exhibit 1 - Administrative Law Court Order, # <u>3</u> Exhibit 2 - Deposition Excerpts of Sam Waldrep, # <u>4</u> Exhibit 3 - SC Court of Appeals Record Index, # <u>5</u> Exhibit 4 - SCDHHS Agency Final Order, # <u>6</u> Exhibit 6 - Deposition Excerpts of Anthony Keck)No proposed order.(Wlodarczyk, Damon). Please see ECF No. <u>105</u> for additional attachments. (Entered: 07/30/2014)
07/30/2014	<u>103</u>	MOTION for Summary Judgment by Robert Levin, Mary S, Nancy S, Richard S. Response to Motion due by 8/18/2014. (Attachments: # <u>1</u> Exhibit Request for Proposal for DDSN Services August 3, 2011, # <u>2</u> Exhibit Olmstead Update No. 4, # <u>3</u> Exhibit Ex Parte Memo of Jacob Chorey February 18, 2010, # <u>4</u> Exhibit Email from DOJ Attorney re Private Right of Action, # <u>5</u> Exhibit S.C. Commission DDSN Worksession dated September 16, 2010, # <u>6</u> Exhibit Wall Street Journal Article re 2010 reductions in SC Medicaid programs, # <u>7</u> Exhibit Affidavit of Seven Jeffcoat, CPA, # <u>8</u> Exhibit 2008 CMS Letter to SCDHHS November 2008 re cost of waiver program, # <u>9</u> Exhibit CMS 2009 Letter to SCDHHS dated November 2009 re cost of waive program, # <u>10</u> Exhibit 2008 LAC Audit of DDSN, # <u>11</u> Exhibit Mullis v. DHHS 2004, # <u>12</u> Exhibit Mullis v. DHHS 2010, # <u>13</u> Exhibit Emails to/from service coordinator re admission to ICF/MR, # <u>14</u> Exhibit R.S. v. DHHS Amicus Brief filed in South Carolina Court of Appeals, # <u>15</u> Exhibit Deposition of Peter Liggett, # <u>16</u> Exhibit Deposition of Elizabeth Hutto, Esq. Part 1, # <u>17</u> Exhibit Deposition of Elizabeth Hutto, Esq. Part 2, # <u>18</u> Exhibit Deposition of Anthony Keck Part 1, # <u>19</u> Exhibit Deposition of Anthony Keck Part 2, # <u>20</u> Exhibit Support Plan of Richard Stogsdill 2012, # <u>21</u> Exhibit B.W. Petition for Remedial Writ, # <u>22</u> Exhibit B.W. v. DHHS, November 19, 2013, # <u>23</u> Exhibit B.W. v. DHHS, December 23, 2013, # <u>24</u> Exhibit Declaration of Nancy Stogsdill, # <u>25</u> Exhibit Declaration of Lennie Mullis 2014, # <u>26</u> Exhibit Affidavit of Lennie Mullis 2009, # <u>27</u> Exhibit Affidavit of Thomas C. Joseph, # <u>28</u> Exhibit Deposition of Kara Lewis, # <u>29</u> Exhibit Declaration of Mary Self, # <u>30</u> Exhibit 2010 Report of SC Comptroller General, # <u>31</u> Exhibit DDSN Directive Re Eligibility for Services, # <u>32</u> Exhibit B.W. v. DHHS Motion to Dismiss of DHHS, # <u>33</u> Exhibit Declaration of Carolyn Brown, # <u>34</u> Exhibit Expert Report of Richard Detwiler, Esq.)No proposed order.(Harrison, Patricia). Please see ECF No. <u>104</u> for additional attachments. (Entered: 07/30/2014)
07/30/2014	<u>104</u>	Additional Attachments to <u>103</u> MOTION for Summary Judgment. First attachment description: Motion for Summary Judgment.(Harrison, Patricia). Modified on 7/31/2014 to edit text(bshr,). (Entered: 07/31/2014)
07/31/2014	<u>105</u>	Additional Attachments to <u>102</u> MOTION for Summary Judgment . First attachment description: Exhibit 5 - Actual Waiver Expenditures Years 2009-11 . (Wlodarczyk, Damon) (Entered: 07/31/2014)
08/18/2014	<u>107</u>	RESPONSE in Opposition re <u>104</u> MOTION for Summary Judgment <i>Entry 103, 103</i> MOTION for Summary Judgment Response filed by Anthony Keck, South Carolina Department of Health and Human Services.Reply to Response to Motion due by 8/28/2014 (Attachments: # <u>1</u> Exhibit 1 - ALC Order, # <u>2</u> Exhibit 2 - Deposition Excerpts of Sam Waldrep, # <u>3</u> Exhibit 3 - Actual Waiver Expenditures, # <u>4</u> Exhibit 4 - Final Agency Order, # <u>5</u> Exhibit 5 - Deposition Excerpts of Anthony Keck)(Wlodarczyk, Damon) (Entered: 08/18/2014)
08/18/2014	<u>108</u>	MOTION for Extension of Time to file <i>Opposition to Summary Judgment</i> by Robert Levin, Mary S, Nancy S, Richard S. Response to Motion due by 9/5/2014. No proposed order.(Harrison, Patricia) (Entered: 08/18/2014)
08/19/2014	109	TEXT ORDER Granting <u>108</u> MOTION for Extension of Time by Robert Levin, Mary S, Nancy S, Richard S. to file Opposition to <u>102</u> motion for Summary Judgment by defendant until 8/25/14. (Response to Motion due by 8/25/2014.). Directed by Honorable Joseph F Anderson, Jr on 8/19/14. (mflo,) (Entered: 08/19/2014)

		08/19/2014)
08/25/2014	<u>110</u>	RESPONSE in Opposition re <u>102</u> MOTION for Summary Judgment Response filed by Robert Levin, Mary S, Nancy S, Richard S. Reply to Response to Motion due by 9/5/2014 (Attachments: # <u>1</u> Exhibit LAC Audit of DDSN June 2014, # <u>2</u> Exhibit South Carolina Comptroll General Report re Kerr & Company, # <u>3</u> Exhibit Kerr & Company Limited Scope Review May 2010, # <u>4</u> Exhibit Draft Kerr Limited Sope Review February 2010, # <u>5</u> Exhibit DDSN Contract Award of Kerr & Company, # <u>6</u> Exhibit Media Release re OIG Report, # <u>7</u> Exhibit DDSN Memo July 30, 2010 re OIG Audit, # <u>8</u> Exhibit OIG Report re DDSN, # <u>9</u> Exhibit DDSN Commission Minutes June 2010, # <u>10</u> Exhibit DDSN Commission Minutes May 2013, # <u>11</u> Exhibit DDSN Report House Healthcare Subcommittee January 2012, # <u>12</u> Exhibit Governor's Proposed Budget FY 2015, # <u>13</u> Exhibit SC Budget and Control Board Minutes 2009)(Harrison, Patricia) (Entered: 08/25/2014)
08/28/2014	<u>111</u>	MOTION for Extension of Time <i>to file Reply re 107</i> by Robert Levin, Mary S, Nancy S, Richard S. Response to Motion due by 9/15/2014. No proposed order.(Harrison, Patricia) (Entered: 08/28/2014)
08/29/2014	<u>112</u>	TEXT ORDER granting <u>111</u> Motion for Extension of Time to file Reply re 107. Reply due by 09/05/2014. Entered at the direction of the Honorable Joseph F. Anderson, Jr. on 08/29/2014.(bshr,) (Entered: 08/29/2014)
09/05/2014	<u>114</u>	REPLY to Response to Motion re <u>102</u> MOTION for Summary Judgment Response filed by Anthony Keck, South Carolina Department of Health and Human Services. (Wlodarczyk, Damon) (Entered: 09/05/2014)
09/08/2014	<u>115</u>	REPLY to Response to Motion re <u>103</u> MOTION for Summary Judgment. Reply to Response filed by Robert Levin, Mary S, Nancy S, Richard S. (Harrison, Patricia). Please see ECF Nos. <u>116</u> , <u>117</u> , and <u>118</u> for additional attachments. (Entered: 09/08/2014)
09/08/2014	<u>116</u>	Additional Attachments to Main Document <u>115</u> Reply to Response to Motion. First attachment description: SC Comp Gen News Rel 11Aug2005 . (Attachments: # <u>1</u> Exhibit SC Comp Gen News Rel 15Aug2006, # <u>2</u> Exhibit SC Comp Gen News Rel 16Aug2007, # <u>3</u> Exhibit SC Comp Gen News Rel 14Aug2008, # <u>4</u> Exhibit SC Comp Gen News Rel 14Aug2009, # <u>5</u> Exhibit SC Comp Gen News Rel 20Aug2010, # <u>6</u> Exhibit SC Comp Gen News Rel FY 2011, # <u>7</u> Exhibit SC Comp Gen News Rel 29Aug2012, # <u>8</u> Exhibit SC Comp Gen News Rel 28Aug2013, # <u>9</u> Exhibit SCCG Comprehensive Ann Fin Rep FY 2013, # <u>10</u> Exhibit SC Comp Gen News Rel 20Aug2014, # <u>11</u> Exhibit Coastal Center tract Post & Courier 12Jun2008, # <u>12</u> Exhibit Coastal Center tract Summerville JS 9Jun2011, # <u>13</u> Exhibit Coastal Center tract Post & Courier 14Jun2011, # <u>14</u> Exhibit Coastal Center tract Budget & Control Board 14Jun2011, # <u>15</u> Exhibit Coastal Center tract B&C Bd 22Aug2006, # <u>16</u> Exhibit Coastal Center tract Summerville JS 25Aug2006, # <u>17</u> Exhibit Coastal Center tract B&C Bd 25Sep2007, # <u>18</u> Exhibit Coastal Center tract Summerville JS 8Apr2011, # <u>19</u> Exhibit Coastal Center tract Post & Courier 28Apr2013, # <u>20</u> Exhibit Coastal Center tract Dorchester Sch. Dist. Two 21Jan2014)(Harrison, Patricia) (Entered: 09/08/2014)
09/08/2014	<u>117</u>	Additional Attachments to Main Document <u>115</u> Reply to Response to Motion. First attachment description: Paul Moore Pleads Guilty & Sentenced in DSS Theft 2009 & 2010 . (Attachments: # <u>1</u> Exhibit USA v Paul Moore 15Jan2009, # <u>2</u> Exhibit USA v Paul Moore Criminal Docket, # <u>3</u> Exhibit USA v Paul Moore Plea Agreement 26Oct2009, # <u>4</u> Exhibit USA v Paul Moore in Judicial Merit Selection, # <u>5</u> Exhibit SCDSS Organizational Chart 2007-2008, # <u>6</u> Exhibit Organized health Care Delivery System Option in Home and Community Based Waiver Services 2001, # <u>7</u> Exhibit conflicts of Interests in Colorado Community Centered Boards Dec 2007, # <u>8</u> Exhibit Medicaid Transportation Report Gaffney Ledger 26Sep2007, # <u>9</u> Exhibit 2008 SC Legislative Audit Council Review of DDSN, # <u>10</u> Exhibit 2009 LAC Review of SCDHHS Medical Transportation, # <u>11</u> Exhibit 2012 LAC Review Budgeting & Deficits at DHHS #1, # <u>12</u> Exhibit 2012 LAC Review Budgeting & Deficits at DHHS #2, # <u>13</u> Exhibit SC Closes Year with Higher-than-expected-Surplus 1Sep2013, # <u>14</u> Exhibit Gov. Haley's Executive Budget FY 2014-15, # <u>15</u> Exhibit State Emplouess Conflict of Interest The Nerve 24Jul2012, # <u>16</u>

		Exhibit Two ex-employees of DHHS at company overpaid \$10M The Tampa Tribune 21Mar2013, # <u>17</u> Exhibit robert M. Kerr III Biography, # <u>18</u> Exhibit Request for proposal by DDSN Aug 2009, # <u>19</u> Exhibit SC Comp Gen Vendor Reports for Public Consulting Group 2013-15, # <u>20</u> Exhibit Public consulting Group Review of DDSN's Current Business Practices July 2014, # <u>21</u> Exhibit DDSN Budget Update Memo 4May2010, # <u>22</u> Exhibit DDSN Director's Apology 9Jun2009, # <u>23</u> Exhibit DDSN Notice MRRD Waiver reductions 1Dec2009, # <u>24</u> Exhibit DDSN Budget Request 2013-14)(Harrison, Patricia) (Entered: 09/08/2014)
09/08/2014	<u>118</u>	Additional Attachments to Main Document <u>115</u> Reply to Response to Motion. First attachment description: DDSN Commission Agenda 21Aug2014 . (Attachments: # <u>1</u> Exhibit Statement of ex-Commissioner Deborah McPherson 21Aug2014, # <u>2</u> Exhibit DDSN Executive Limitations Policy 21Aug2014, # <u>3</u> Exhibit New Payroll Systems Causing Problems 9Nov2011, # <u>4</u> Exhibit SC Comp Gen Budget Report FY 2013, # <u>5</u> Exhibit Application for HCBS Waiver Submission Date 1Jul2008, # <u>6</u> Exhibit Application for HCBS Waiver Effective Date 1Jan2010, # <u>7</u> Exhibit KW v MS - Defendants' Return to Petition for original Jurisdiction in SC Supreme Court 11Jan2010, # <u>8</u> Exhibit KW v MS -Amicus Curiae in Support of Plaintiff's Petition for Original Jurisdiction, # <u>9</u> Exhibit CMS Waivers for SC, # <u>10</u> Exhibit DDSN Commission Minutes 5Jun2009, # <u>11</u> Exhibit DDSN commission Minutes 17Jul2009, # <u>12</u> Exhibit DDSN Commission Minutes 20Aug2009, # <u>13</u> Exhibit Support Plan for Robert Levin 19Nov2013, # <u>14</u> Exhibit Budget for Rob Levin 15Nov2013, # <u>15</u> Exhibit Budget for richard Stogsdill 21Jan2009, # <u>16</u> Exhibit Physician's order for nursing services for Richard Stogsdill 12Jun2014, # <u>17</u> Exhibit richard Stogsdill's Medical Records, # <u>18</u> Exhibit Transcript Richard Stogdill's DHHS Hearing 11May2010, # <u>19</u> Exhibit Amounts Allocated, Spent, and Carried Forward or Lapsed, DHHS & DDSN, 2005-2014, # <u>20</u> Exhibit JE v SCDHHS - Settlement Agreement 29May2012, # <u>21</u> Exhibit BH v SCDHHS - Final Order and Decision of Administrative Law Court 19Jul2011, # <u>22</u> Exhibit BW v SCDHHS -Motion to Dismiss and Response, # <u>23</u> Exhibit State Agencies Sitting on Millions of Taxpayer Dollars, The Nerve 27Aug14)(Harrison, Patricia) (Entered: 09/08/2014)
09/08/2014	<u>119</u>	MOTION for Extension of Time <i>to File One Day out of Time</i> by Mary S, Nancy S, Richard S, Rob L. Response to Motion due by 9/25/2014. No proposed order.(Harrison, Patricia) (Entered: 09/08/2014)
09/09/2014	120	TEXT ORDER granting <u>119</u> Motion for Extension of Time <i>to File One Day out of Time</i>. Entered at the direction of the Honorable Joseph F. Anderson, Jr. on 09/09/2014.(bshr,) (Entered: 09/09/2014)
09/22/2014	<u>121</u>	NOTICE of Request for Protection from Court Appearance by Patricia L Harrison for 09/30/14 - 10/06/14 (Harrison, Patricia) (Entered: 09/22/2014)

PACER Service Center			
Transaction Receipt			
09/25/2014 12:04:05			
PACER Login:	ph0727:2758162:0	Client Code:	
Description:	Docket Report	Search Criteria:	3:12-cv-00007-JFA
Billable Pages:	10	Cost:	1.00

Exhibit 2

Nancy Stogsdill's Affidavit
September 25, 2014

AFFIDAVIT OF NANCY G. STOGSDILL

September 25, 2014

Now comes Nancy G. Stogsdill, who swears and affirms that:

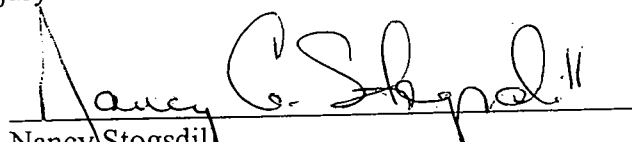
1. I am the mother of Richard S. who has lived in our family home since he was born.
2. Richard has profound cerebral palsy and he is unable to walk or get up out of the bed, he needs total assistance in toileting, bathing and dressing, he is unable to prepare food or to get a glass of water out of the faucet.
3. Richard has a history of terrible spasms in his legs that cause extreme pain. These come on without warning and we have to lift him out of his wheelchair and onto the bed to massage his legs until the pain goes away.
4. At the first hearing in 2009, we presented David Todd, a nurse who has worked with Richard for years and is very familiar with his condition and his medical needs.
5. Mr. Todd testified that the services Richard was receiving in 2009, when his school based services were reduced, were inadequate to meet his needs at home.
6. No qualified medical professional testified at Richard's first hearing and only his DDSN service coordinator had even met Richard before.
7. When Richard's father was living, both of us were totally exhausted from trying to provide the services he needs and now that his father is dead, I would not be able to keep Richard at home without significantly more support than is allowed under the waiver amendments.
8. Families did not know that DDSN and DHHS were planning this mass reduction in services until the very end of the legislative session in 2009 and the cuts took effect for everyone who did not file an appeal before the legislature reconvened.
9. Recently, Richard has been in and out of the hospital with kidney stones and these, too, cause terrible pain that the drugs that can be administered at home just can't control.
10. Richard wants to continue to live at home and to have opportunities to go out into the community and I want him to remain in the least restrictive setting.
11. Richard is totally opposed to entering an ICF/MR for residential services, or even for respite.

12. Richard would be unable to defend himself and he would not be safe at a workshop or a congregate group home setting.
13. Requiring Richard to sit around a table at a workshop watching persons who have cognitive disabilities do busy work would be tortuous to Richard.
14. When Richard was in school, he received one-on-one supervision during the school day and he was a valued member of the student body who had a lot of friends.
15. After he graduated from high school, Richard tried going to Vocational Rehabilitation to get a job.
16. They were not able to provide for his personal care needs there, and I would have to leave my job to take care of his toileting needs.
17. VR was unsuccessful in locating a job for Richard, so the hours of the day when he had been in school were not covered anymore.
18. I had to quit my full time job and now I have six part time jobs, so that I can run home between jobs and have more flexibility to be there when a caregiver is absent.
19. DDSN never told us that having adult companion services was a feasible alternative under the waiver to the workshop, or how to access those services.
20. It took months (more than 90 days) after the first hearing officer ordered DDSN to provide companion services before they were put into place and they have been very sporadic due to the rate of pay and the failure to enlist sufficient providers of this service.
21. If the PCA/Adult Companion combined cap were to be imposed on Richard, he would no longer have access to his companion.
22. Richard's father became ill in 2012 with cancer and he was unable to help me take care of Richard prior to his death a year ago.
23. When Richard's father was very ill, DDSN provided some additional respite hours, but they refused to exceed the respite cap established in 2010 or to provide additional PCA hours.
24. The only alternative DDSN offered was to place Richard in an ICF/MR in a large regional center, where he would be segregated from non-disabled persons and would be isolated from his family.
25. My service coordinator told me that we were capped at the number of PCA hours Richard

was receiving when we filed his administrative appeal and that if we lost the appeal, his services would be cut to 28 hours a week of PCA and Companion (combined).

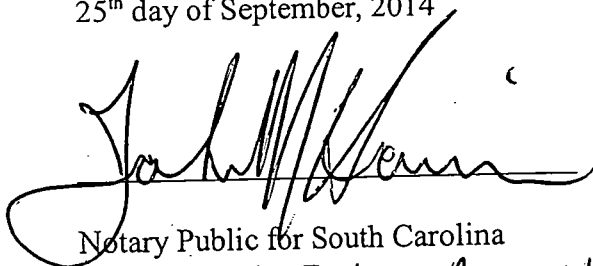
26. Physical therapy, occupational therapy and speech services are included Richard's 2012 plan of care, but they have not been provided. Exhibit 20.
27. Since Richard's father died and I no longer have the support he provided prior to his illness, Richard has been repeatedly hospitalized and has been in tremendous pain.
28. I am exhausted now from caregiving responsibilities and, if Richard's services are cut, he will likely have to move from our home, which breaks my heart to think how traumatized and isolated he will feel.
29. I am getting older and I am just not able to lift and to hold up the way I could when I was younger.
30. I have a friend who served on the Kershaw County DSN Board with me whose son has disabilities similar to Richard's.
31. She attempted to appeal the reductions in her son's services, but when it became clear that DHHS intended to impose them, she was forced to place him in a nursing home, where he is the youngest resident by many, many years.
32. Her son's condition has declined terribly in the nursing home, since he moved out of his home, and he has developed decubitus ulcers and infections.
33. My biggest fear in life is that this could happen to my son. This parent, like me, always believed that her son would always live at home, and it is impossible for parents like us to allow our minds to imagine what it would be like for our children if they were sent to live in an institution with only old and disabled persons.
34. Parents are afraid of retaliation and Richard's psychological services provider was terminated soon after she signed an affidavit in support of Richard and advocated for exemptions to these service caps for other persons.
35. If Richard's services were to be cut, I would be faced with draining my retirement savings to take care of him, or placing him in an institution, where taxpayers would pay more than the cost of his care at home, but I would not be responsible for his costs there.
36. Richard's doctor has said that his mental and physical health would deteriorate if he were to be placed in a congregate setting and I know my own limits and totally agree with that assessment.

I have read this Affidavit consisting of four pages (including my signature) and I swear under penalties of perjury that it is true and correct to the best of my knowledge and information.


Nancy Stogsdill

September 25, 2014

Sworn to before me on this
25th day of September, 2014



Notary Public for South Carolina

My Commission Expires: August 14, 2015

Exhibit 3

S.P. v. SCDHHS

Appeals Case # 05-MISC-025 (MR/RD)
SCDHHS' Hearing Officer's Decision Not
to Enforce Order of the US Fourth Circuit
April 28, 2013

RULING ON PETITIONER'S MOTION TO ENFORCE ORDER OF THE
UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT AND
FINAL ADMINISTRATIVE ORDER IN THE APPEAL MATTER OF INTERIM
CARE OF S.P. (PETITIONER)

Appeals' Case # 05-MISC-025 (MR/RD)

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 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.).

STATEMENT OF THE CASE

The Petitioner has been receiving Medicaid services under the Mental Retardation/Related Disabilities (MR/RD) Waiver program. Via Notice of April 27, 2005 the Respondent's (South Carolina Department of Health and Human Services') agent, South Carolina Department of Disabilities and Special Needs (SCDDSN) notified the Petitioner's father/representative that the Petitioner was no longer eligible for MR/RD Waiver Medicaid services effective May 7, 2005 as she no longer met the Intermediate Care Facility for the Mentally Retarded (ICF/MR) Level of Care (LOC) criteria. The Petitioner's father appealed this determination and a hearing was convened on January 24-26, 2006 and April 27-28, 2006. Via Final Administrative Decision of June 5, 2006, this Hearing Officer affirmed the Respondent's determination, finding that the Petitioner no longer met the Intermediate Care Facility for the Mentally Retarded (ICF/MR), Level of Care (LOC) criteria. This Hearing Officer's Final Administrative Decision was appealed to the South Carolina Administrative Law Court. Via Order dated June 28, 2007, State of South Carolina Administrative Law Court Judge, Paige J. Gossett directed this Hearing Officer to make a determination as to the Petitioner's interim care until Judge Gossett made her final decision on Petitioner's appeal. Subsequently, via Order of July 30, 2007 this Hearing Officer determined that the Petitioner would be moved to another Community Training Home II (CTH II) that is qualified to provide those services that Respondent has determined the Petitioner requires. Furthermore, the Petitioner's new CTH II would be as close as possible to the Petitioner's home. Via Order of June 20, 2008, State of South Carolina Administrative Law Court Judge, Paige J. Gossett affirmed this Hearing Officer's determination which found the Petitioner no longer eligible for MR/RD

Waiver Medicaid services. Petitioner vigorously appealed Judge Gossett's Order of June 20, 2008 and via Supreme Court of South Carolina Order of Reversal and Remand filed December 28, 2011, the South Carolina Administrative Law Court and this Hearing Officer were directed to determine if, applying the proper legal standard for mental retardation (onset prior to age twenty-two), the Petitioner does meet the ICF/MR LOC criteria and is; therefore, eligible to receive MR/RD Medicaid Waiver services.

FINDINGS OF FACT

- (1) Via Final Administrative Decision of June 5, 2006, this Hearing Officer affirmed Respondent's determination that the Petitioner no longer met the Intermediate Care Facility for the Mentally Retarded (ICF/MR), Level of Care (LOC) criteria and; therefore, was not eligible to receive Medicaid services under the Mental Retardation/Related Disabilities (MR/RD) Waiver program.
- (2) This Hearing Officer's Final Administrative Decision was appealed to the South Carolina Administrative Law Court. Via Order dated June 28, 2007, State of South Carolina Administrative Law Court Judge, Paige J. Gossett directed this Hearing Officer to make a determination as to the Petitioner's interim care until Judge Gossett made her final decision on Petitioner's appeal.
- (3) Via Order of July 30, 2007, this Hearing Officer determined that the Petitioner would be moved to another Community Training Home II (CTH II) that is qualified to provide those services that Respondent has determined the Petitioner requires, and furthermore, the Petitioner's new CTH II would be as close as possible to the Petitioner's home.
- (4) With no evidence to the contrary, Petitioner never appealed this Hearing Officer's July 30, 2007 Order.
- (5) Via Order of June 20, 2008, State of South Carolina Administrative Law Court Judge, Paige J. Gossett affirmed this Hearing Officer's determination which found the Petitioner no longer eligible for MR/RD Waiver Medicaid services as she did not meet the ICF/MR level of care criteria.
- (6) Petitioner vigorously appealed Judge Gossett's Order of June 20, 2008 and via Supreme Court of South Carolina Order of Reversal and Remand filed December 28, 2011, the South Carolina Administrative Law Court and this Hearing Officer were directed to determine if, applying the proper legal standard for mental retardation (onset prior to age twenty-two), the Petitioner does meet the ICF/MR LOC criteria and is; therefore, eligible to receive MR/RD Medicaid Waiver services.

(7) In order to comply with the Supreme Court of South Carolina's Order of Reversal and Remand filed December 28, 2011, this Hearing Officer convened multiple days of evidentiary hearings throughout 2012 and 2013.

(8) During the course of the extended hearing, Petitioner filed a Motion to Enforce Order of the United States Court of Appeals for the Fourth Circuit and Final Administrative Order in the Matter of Interim Care of Robyn Sommer Pruitt. In this Motion, Petitioner asserts that in March 2011, the United States Court of Appeals for the Fourth Circuit ordered Respondent to provide residential habilitation services to Petitioner pending a final determination as to her eligibility for the MR/RD Medicaid Waiver. Additionally, Petitioner requests this Hearing Officer to either require Respondent to provide residential habilitation services in a CTH II "pursuant to the placement order," or a written order stating that this tribunal has determined that its jurisdiction is limited solely to the issue of whether the Petitioner is mentally retarded.

(9) South Carolina Code of Laws, Section 1-23-380 informs parties who have received a negative determination subsequent to an administrative hearing, how that negative determination may be appealed and reads as follows:

SECTION 1-23-380. Judicial review upon exhaustion of administrative remedies.

A party who has exhausted all administrative remedies available within the agency and who is aggrieved by a final decision in a contested case is entitled to judicial review pursuant to this article and Article 1. This section does not limit utilization of or the scope of judicial review available under other means of review, redress, relief, or trial de novo provided by law. A preliminary, procedural, or intermediate agency action or ruling is immediately reviewable if review of the final agency decision would not provide an adequate remedy. Except as otherwise provided by law, an appeal is to the court of appeals.

(10) Whether Petitioner is appealing this Hearing Officer's July 30, 2007 Order or as Petitioner alleges, the March 2011 Order by the United States Court of Appeals for the Fourth Circuit directing Respondent to provide residential habilitation services to Petitioner pending a final determination as to her eligibility for the MR/RD Medicaid Waiver, this Hearing Officer does not have the authority to hear the appeal of either decision. This Hearing Officer has already ruled as to Petitioner's placement in the July 30, 2007 Order and does not have the authority to again rule on the exact same issue. Additionally, if as Petitioner alleges, the United States Court of Appeals for the Fourth Circuit directed Respondent to provide residential habilitation services to Petitioner pending a final determination as to her eligibility for the MR/RD Medicaid Waiver, this Hearing Officer does not have the authority to either enforce the Fourth Circuit's Order or to hear an appeal of the Fourth Circuit's decision, pursuant to South Carolina Code of Laws, Section 1-23-380.

(11) 42 CFR §431.200(a)(b) directs this tribunal when granting the opportunity for a fair hearing to a Medicaid applicant or recipient and reads as follows:

This subpart--

(a) Implements section 1902(a)(3) of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly;

(b) Prescribes procedures for an opportunity for a hearing if the State agency or PAHP takes action, as stated in this subpart, to suspend, terminate, or reduce services, or an MCO or PIHP takes action under subpart F of part 438 of this chapter; and....

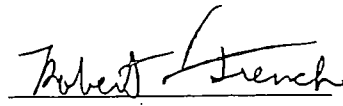
(12) This Hearing Officer has already issued an Order with regard to Petitioner's placement in his July 30, 2007 Order, this Hearing Officer has fulfilled his duty pursuant to 42 CFR §431.200(b).

(13) If as Petitioner alleges, the United States Court of Appeals for the Fourth Circuit directed Respondent to provide residential habilitation services to Petitioner pending a final determination as to her eligibility for the MR/RD Medicaid Waiver, this Hearing Officer does not have the authority to either enforce the Fourth Circuit's Order or to hear an appeal of the Fourth Circuit's decision pursuant to 42 CFR §431.200(b).

DECISION

Based on the Findings of Fact, it is not within this Hearing Officer's jurisdiction to enforce or hear an appeal of, as alleged by Petitioner, the United States Court of Appeals for the Fourth Circuit's March 2011 Order, which directed Respondent to provide residential habilitation services to Petitioner pending a final determination as to her eligibility for the MR/RD Medicaid Waiver. Additionally, this Hearing Officer does not have the authority to again rule on Petitioner's placement as he has already done that in his July 30, 2007 Order.

AND IT IS SO ORDERED.


Robert French
Chief Hearing Officer

Dated at Columbia,
South Carolina

April 28, 2013

Exhibit 4

B.W. v. SCDHHS

Appeals Case # 07-MISC-028(Remanded)

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. Linn*, 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 5

B.W. v. SCDHHS

Appeals Case # 07-MISC-028(Remanded)

Order Denying Reconsideration of

Final Administrative Order of November 19, 2013

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 6

Brook Waddle v. SCDHHS
Administrative Law Court
Docket No. 13-ALJ-08-0603-AP
Petition/Complaint for Remedial Writ
June 29, 2014

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Brook Waddle,
Appellant/Respondent,

Docket No. 13-ALJ-08-0603-AP

v.

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

PETITION/COMPLAINT FOR REMEDIAL WRIT

Petitioner Brook Waddle applies for an order requiring Respondent to immediately comply with the Orders of the Department of Health and Human Services (DHHS) Hearing Officer in this case. The Record transmitted by the DHHS Office of Hearings and Appeals to the Administrative Law Court is hereby incorporated by reference to this Petition/Complaint in its entirety.

On May 1, 2014, Brook first petitioned this Court, after the most recent remand to DHHS (this is the third appeal to the Administrative Law Court from Brook's "fair hearing" appeal filed with DHHS in 2007), requesting an order to require DHHS to immediately comply with the two Orders of hearing officer Hutto while this appeal is pending. Order dated November 19, 2013 is referred to as "Hutto Order I" (Exhibit 1) and the Order dated December 23, 2013 is referred to herein as "Hutto Order II" (Exhibit 2). *Brook Waddle v. DHHS*, Case No. 07-MISC-028, November 19, 2013 (Exhibit 1) and December 23, 2013 (Exhibit 2). The May 1, 2014 Petition (the "Petition") is attached hereto as Exhibit 3.

FILED

JUN 23 2014

SC ADMIN. LAW COURT

The Medicaid Act and the regulations that interpret the Act require a final state administrative decision to be made with reasonable promptness. 42 C.F.R. 1396a(a)(8). In *Doe v. Kidd*, the United States Court of Appeals for the Fourth Circuit determined that DHHS "abdicated their responsibility to furnish Doe with the necessary services in the least restrictive environment" in violation of the "reasonable promptness" mandate of the Medicaid Act. Case No.10-1191 (4th Cir. March 24, 2011). Executive Branch officials in Brook's case have acted with conscious disregard for her health and welfare and have blatantly violated the reasonable promptness requirements of the Medicaid Act and the requirement to issue a final state administrative decision within 90 days. 42 C.F.R. 431.244(f). In *Shakhnes v. Berlin*, the Court of Appeals for the Second Circuit ruled that the right to an opportunity for Medicaid "fair hearings" contained in 42 U.S.C. 1396a(a)(3) includes a right to a final state administrative decision following such hearings. 689 F.3d 244 (2nd Cir. 2012). In *Shakhnes*, the court held: "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.'" Citing *Harris v. James*, 127 F.3d 993, 1009 (11th Cir.1997). Section 431.244 of Title 42 of the Code of Federal Regulations— entitled "Hearing decisions" — clearly provides that the State agency "must take final administrative action ... [o]rdinarily, within 90 days" of the date a fair hearing is requested. *See* 42 C.F.R. § 431.244(f)(1)(ii) (" regulation").

This Court is bound in this case to give deference to the State Medicaid Manual issued by the federal Medicaid Agency, CMS. *Shakhnes* at 259. That Manual "makes available to all State Medicaid agencies ... informational and procedural material needed by the States to administer

the Medicaid program.... The manual provides instructions, regulatory citations, and information for implementing provisions of Title XIX of the Social Security Act (the Act). Instructions are official interpretations of the law and regulations, and, as such, are binding on Medicaid State agencies")" *Id.* at fn 11. The State Medicaid Manual provides that "[a] *conclusive decision* in the name of the State agency shall be made by the hearing authority." *Manual* § 2903.2(A) (emphasis added). *Shakhnes*, *Id.* Of great importance in this case are the instructions in *Shakhnes* and the State Medicaid Manual regarding remands of fair hearings:

Although the hearing authority may remand the matter to a local hearing officer where "the materials submitted are insufficient to serve as [a] basis for a decision," the *Manual* clarifies that such a remand " *is not a substitute for definitive and final administrative action.* " *Id.* (emphasis added) (quotations omitted). If "final administrative action" refers to the issuance of a final agency decision, the foregoing clarification is justifiable: It could make sense to clarify that a decision to remand a matter for further consideration does not discharge the obligation to issue a *final decision*... The decision to remand a matter for further consideration could never constitute the implementation of relief.

Id. Not only does the State Medicaid Manual require the State to issue a final decision within 90 days, in addition, § 2903.3 of the *Manual* — entitled "State Agency Responsibility In Carrying Out The Hearing Decision" — provides that Defendants "are responsible for assuring that the [hearing authority]'s decision *is carried out promptly.* " *Id.* § 2903.3(A) (emphasis added). "

In her Petition, Brook argued that S.C. Code 1-23-380 applies in this case. Petition at 2. That statute clearly and unambiguously provides that filing a notice of appeal does not stay enforcement of the agency decision. In addition to her request for an order requiring DHHS to comply with the order of its hearing officer, Brook asked this Court to issue a Rule to Show Cause and an order holding DHHS in contempt, but her Petition was not limited to those issues.

Petition at 3.

Brook's position regarding the stay is also supported by Rule 241 of the South Carolina Rules of Appellate Procedure. That Rule provides that the general rule is that "the service of a notice of appeal in a civil matter acts to automatically stay matters decided in the order, judgment, decree or decision on appeal, and to automatically stay the relief ordered in the appealed order, judgment, decree or decision." Rule 241(1)(a). However, that Rule contains exceptions that are found in "statutes, court rules, and case law." Rule 241(1)(b). This Rule, which, unlike ALC Rule 34, has been approved by the South Carolina Supreme Court, provides a specific exception to the general rule for Appeals from administrative tribunals under the Administrative Procedures Act.

Brook also referenced in her Petition the general authority that this Court has to issue a remedial writ to require DHHS to enforce the orders. *Id.* at 3. The authority this Court has to order DHHS to comply with those orders exists, whether or not a stay is in place. Brook begged in her May 1, 2014 Petition that "Justice demands, as a matter of law and equity" and that DHHS should be ordered to immediately comply with the Order of its own agency hearing officer. *Id.* at 2 to 3. In the concluding paragraph of her Petition, DHHS was placed on notice of Brook's prayer for the following specific relief from this Court:

The Court should enforce the Order of this Court and the DHHS Hearing Officer, requiring DHHS to immediately provide the services ordered by Brook's physician and to promptly pay the amount the DHHS Hearing Officer found due...

Petition at 4. The relief requested in this Petition/Complaint is no surprise to DHHS. Brook has provided DHHS with written notice that the agency did not provide her before reducing her

services during this appeal, in violation of its own policies.

As justification for its refusal to provide the services ordered by Hearing Officer Hutto, Respondents have relied upon Rule 34 of the Rules of the Administrative Law Court, which provides:

Rule 34. Automatic Stay of Proceedings Upon Appeal

The filing of an appeal from the final decision of an agency shall stay the final decision of that agency unless the effect of filing an appeal is otherwise established by statute, the Administrative Procedures Act notwithstanding; or the administrative law judge has entered an order regarding the effect of the proceedings in the agency. Notwithstanding the foregoing, upon the filing of an appeal from the final decision of an agency, any party may apply to the administrative law judge for an order regarding the effect of the appeal on the agency decision.

But, as Brook's counsel argued at the hearing on her May 1, 2014 Petition, this Rule is in direct conflict with the state statute contained at S.C. Code 1-23-380(2), which specifically states that the agency's order is not stayed on appeal to the appellate court. That statute provides for a stay only in the event that a party files a petition under Rule 65 of the South Carolina Rules of Civil Procedure - otherwise, the order must be enforced.¹ The agency has failed to file a Rule 65

¹ Rule 65(f)(1) provides that:

No writ of mandamus, habeas corpus, or other remedial writ shall be granted without notice of motion for the writ to the adverse party, which notice shall be served, together with the summons and complaint, in event no summons and complaint have previously been filed and served in the action, upon the adverse party in accordance with the provisions of Rules 4 and 5. Such notice and motion shall be supported by affidavit or verified complaint setting forth clearly the facts entitling the moving party to such writ. The motion shall be heard upon such notice as the court may prescribe, and the court shall proceed to hear and determine such motion as expeditiously as the ends of justice require. Unless a different time be prescribed by the court, the adverse party shall plead to the complaint and respond to such motion in the time prescribed by these rules for other civil actions.

petition in this case. The Rules of the South Carolina Administrative Law Court are not approved by the Supreme Court, because the ALC is an administrative agency within the Executive Branch which is not part of the Judicial Branch of government. DHHS and the ALC have clearly exceeded the scope of their authority by failing to give deference to the order of the DHHS hearing officer. To allow DHHS to stay its hearing officer's order would violate the Separation of Powers provision of the South Carolina Constitution, as well as federal law requiring a final state administrative decision within 90 days. It is well settled law that an agency policy or rule can never trump a statute. The interpretation of a statute is a question of law. *CFRE, LLC v. Greenville County Assessor*, 395 S.C. 67, 74, 716 S.E.2d 877, 881 (2011). The South Carolina Supreme Court has held that it is "[o]nly when the literal application of the statute produces an absurd result will we consider a different meaning." *Id. Citing Se.-Kusan, Inc. v. S.C. Tax Comm'n*, 276 S.C. 487, 499, 280 S.E.2d 57, 58 (1981). The Supreme Court ruled that it is legal error for the Court to "search for an interpretation ... where the plain and unambiguous language leaves no room for construction." *Id.* The language of S.C. Code of Laws 1-23-380 could not be more plain and unambiguous. It states: "...the serving and filing of the notice of appeal does not itself stay enforcement of the agency decision" and this Executive Branch agency is without authority to ignore the plain meaning of that statute. S.C. Code of Laws 1-23-380.

Appellant believes that S.C. Code 1-23-380 is controlling and that this Court is bound to order DHHS to comply with that statute. However, out of an abundance of caution, in order to avoid further delay, in the event that the Court determines this Rule to be applicable to Brook's request for relief, this Petition has been styled as a Petition/Complaint and it is being served upon the Attorney General for the State of South Carolina, as well as the South Carolina Department of Health and Human Services pursuant to Rule 4 of the South Carolina Rules of Civil Procedure.

Brook complained in her May 1, 2014 Petition that DHHS has not filed a motion to request a stay pursuant to Rule 65 of the South Carolina Rules of Civil Procedure. In her Petition, Brook argued that justice demands, as a matter of law and equity, that DHHS should be ordered to immediately comply with the Order of its own agency hearing officer. Petition at 2 and 3.

The South Carolina Supreme Court has held that where an agency's interpretation conflicts with the plain language of a statute, that interpretation must be rejected. *Sparks v. Palmetto Hardwood, Inc.*, 406 S.C. 124, 750 S.E.2d 61, 63 (S.C. 2013). An agency may not resort to "subtle or forced construction to limit or expand the statute's operation." *Hitachi Data Systems Corp. v. Leatherman*, 309 S.C. 174, 420 S.E.2d 843 (1992). An agency's construction of a statute is not dispositive when it contradicts the terms contained in the South Carolina Code of Laws. *Gilstrap v. South Carolina Budget and Control Bd.*, 310 S.C. 210, 423 S.E.2d 101 (1992).

S.C. Code of Laws 1-23-380 and Rule 34, which Respondent relies upon, are both discussed in the book South Carolina Administrative Practice and Procedure, Second Edition. Lowell, Randolph R. et al. In a chapter that was written by attorney Kenneth P. Woodington, who represents DHHS in other actions pending in both state and federal courts, Mr. Woodington recognized that Rule 34 provides that "after an appeal has been filed, a party may move before the assigned ALC 'for an order regarding the effect of the appeal on the agency decision.'" Importantly, Mr. Woodington notes that **neither the Administrative Procedures Act nor Rule 34 require any "motion before the agency as a precondition to seeking interim relief from the ALC."** *Id.* at 450. Of tremendous importance in this case is that, according to Mr. Woodington "Motions requesting interim relief before an ALJ are generally, as a practical matter,

heard within several days.” Id. But, more than six weeks have passed since Brook filed her May 1, 2014 motion requesting interim relief and none has been provided. Even more egregious is the fact that more than 2,555 days have passed since Brook first requested additional services than those being provided upon her discharge from the hospital and the Executive Branch has done nothing but to cut her services further, placing Brook’s life at risk, while her appeal has been cycled between DHHS and the ALC. This Court has the authority, and the duty, to stop this dangerous nonsense.

Mr. Woodington acknowledges in South Carolina Administrative Practice and Procedure that there are no cases defining the standard an applicant must meet to obtain interim relief from the Administrative Law Court. Id. Exhibit 7. As Randolph R. Lowell wrote in “*To Stay or Not to Stay: Automatic Stays Before the Administrative Law Court in DHEC Matters*,” published in the September 2008 South Carolina Lawyer: “As a matter of general law, the lifting of a stay is within the sound discretion of the ALJ.” Exhibit 8. Citing generally *Carolina Water Serv., Inc. v. Lexington County Joint Mun. Water & Sewer Comm’n*, 625 S.E.2d 227 (Ct. App. 2006), *overruled on other grounds*, 644 S.E.2d 681 (2007). S.C. Code of Laws 1-23-600(H)(4) provides that “upon motion by any party, the court shall lift the stay for good cause shown or if no irreparable harm will occur, then the stay shall be lifted.” As Lowell noted in this article: “The standard is certainly less than what is required to obtain injunctive relief.” *Supra*. Exhibit 8.

Thus, as noted by Lowell, a party need only demonstrate either good cause *or* no irreparable harm to DHHS in order to have the stay lifted. “Good cause” is defined in Black’s Law Dictionary as a “legally sufficient reason.” Black’s Law Dictionary 235 (8th ed. 2004). It is

unclear what threshold or balancing test the ALC must apply in determining "good cause." Id. However, in *S.C. Dep't of Motor Vehicles v. Lajuenesse*, in a DMV context, the Administrative Law Judge suggested that good cause "may" require a balancing. 06-ALJ-21-0270-AP (March 4, 2008). Other ALC orders addressing injunctive relief under ALC Rule 16 or in the context of other stay issues have also utilized a balancing approach. In a DHEC matter analyzing the 2008 language, an ALJ concluded that the stay should be lifted after balancing the positions of the parties. *Hill v. S.C. Dep't of Health & Envtl. Control*, 08-ALJ-07-0183-CC (July 10, 2008).

In balancing the equities of this case, the court should consider that the Appellant has presented evidence that the cost of her care is more expensive if the services she needs are not provided in her home setting. R. at 918. As predicted, Brook has required far more expensive treatment in the hospital as a result of the services her physicians ordered not being provided. R. at 918 to 921. When DHHS imposed caps on services in 2010, the cost of DDSN's largest Medicaid waiver program, the MR/RD Medicaid program (now ID/RD), went up by more than \$52 million a year, and the average cost per participant increased by more than \$7,000 per participant per year. Exhibits 9 and 10.

Compared to any potential harm to Defendants, the harm to Brook in this case is extreme. It includes both likelihood of serious risk of both physical injury and psychological harm.. Exhibit 5. Affidavit of Lennie Mullis. Brook will be forced from her home into either a hospital or institutional setting to meet her needs that can otherwise be met at home, if her doctors' orders were to be followed by DHHS. Id. and R. 918. Her living arrangement will not be easily reestablished once dismantled. She will likely develop bed sores and the resulting infections

which will be more expensive to treat than the cost of her care at home. R. 920. There is no justifiable benefit - economic or otherwise - to the State in refusing to comply with the orders of the DHHS hearing officer. Providing Brook home-based services benefits taxpayers, because the costs of repeated hospitalizations and treatment of decubitus ulcers will far exceed the cost of her receiving services at home. R. 920.

In this case, DHHS has produced no evidence that it will suffer irreparable harm if the services ordered by its own hearing officer are provided. It has failed to meet its burden to prove that the State's system will be "fundamentally altered" if services ordered by Brook's physician were to be provided. *Olmstead v. L.C.*, 527 U.S. 589 (1999). It is likely that the costs to provide medical services to Brook will be less if these services are provided at home, due to the high costs of lengthy hospitalizations. According to testimony presented at the 2009 hearing, the cost of 92 days in the hospital was more than \$277,000.00. R. 979 and 980. While hospitalized after the remand to DHHS by Judge McLeod, Brook actually developed a decubitus ulcer. Exhibit 4. Affidavit of Sandra Waddle. The cost of treating just a single decubitus ulcer can be \$70,000. R. at 920. Brook has provided an affidavit from an RN with extensive experience working with persons who have severe disabilities who signed a sworn statement stating that:

The services ordered by Dr. Silvestri ...are cost effective, considering the high cost of hospitalizations required by the lack of care prescribed.

R. at 921.

Contrary to the opinion as to the applicable standard set forth by Lowell in this article, in Lowell's book, Woodington suggests that the Administrative Law Judges have applied the same standards for requests for interim relief as the court applies to the issuance of preliminary

injunctions in other civil actions. Lowell. at 451. The South Carolina Supreme Court addressed the requirements for a preliminary injunction in *Hook Point, LLC v. Branch Banking and Trust Co.* and these criteria will be discussed below, 397 S.C. 507, 725 S.E.2d 681 (S.C. 2012):²

A preliminary injunction should issue only if necessary to preserve the status quo ante, and only upon a showing by the moving party that without such relief it will suffer irreparable harm, that it has a likelihood of success on the merits, and that there is no adequate remedy at law." *Poynter Investments, Inc. v. Century Builders of Piedmont, Inc.*, 387 S.C. 583, 586-87, 694 S.E.2d 15, 17 (2010).

It should be noted that in this case, Brook has requested more than maintaining the current status quo. Registered Nurse Kathy Hoover, psychological services provider, Lennie Mullis, LPN Galus and speech and language specialist, Sandra Ray, as well as Brook's physicians have found the status quo to provide services that are woefully inadequate to meet Brook's complex medical needs. R. 477 to 487, 502 to 547, and Record of 2009 hearing at 905 to 906, 918. As in *Peter B. v. Sanford*, DHHS has failed to provide any evidence from a qualified medical source to contradict these findings or to justify maintaining the status quo. Exhibit 6.

Nevertheless, the elements which are required for a preliminary injunction are clearly present in this case, i.e. (1) irreparable harm, (2) likelihood of success on the merits, and (3) no adequate remedy at law." *Poynter Investments, Inc. v. Century Builders of Piedmont, Inc.*, 387 S.C. 583, 586-87, 694 S.E.2d 15, 17 (2010). These elements will be discussed below:

- A. *Brook will suffer irreparable harm if the services and payments contained in the Orders are not provided.*

In *Peter B. v. Sanford*, the federal magistrate noted that:

² By including these criteria, Brook does not waive her position that the order was not stayed by operation of law.

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

Exhibit 6. Then Magistrate Judge Bruce Howe Hendricks (now District Court Judge) found in *Peter B.* that "institutionalization, as a result of a denial of benefits, constitutes, legally speaking, the kind of harm which equitable relief is suited to enjoin." *Id.* As in that case, Brook has established in the record and the attached declarations the specific evidence of the kind of injury she would face should her Petition/Complaint not be granted. She has demonstrated that her mental and physical condition have declined since her appeal was filed in 2007 and the agency has repeatedly reduced her services, instead of providing the increase in services she has requested. As in *Peter B.*, her anxiety and depression has increased. DHHS has agreed that Brook needs psychological services, yet these services have never been authorized, despite repeated requests. Exhibit 5, Affidavit of Lennie Mullis. Likewise with services of a registered nurse - DHHS recognized at the hearing the need for those services, yet none have been provided in conscious disregard for the consequences. Exhibit 4. Affidavit of Sandra Waddle. As with Chip E. in *Peter B.*, because Brook is cognizant of her condition and her needs, "the prospect of institutionalization is most terrorizing" to her. The district court found that just the threat of irreparable injury to Chip existed "exactly in the lost opportunity that community living offers."

Brook faces this same irreparable harm.

As recognized by that Court “Confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” *Id.* Being institutionalized would subject Brook to “all of the adjunct humiliations that violation of personal space and person imposes.” *Id.* This Court should recognized that “Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” *Id.* As Judge Hendricks noted, the United States Supreme Court has recognized that “Where such an experience can be avoided... it should be.”

Other federal courts have found that the various forms of psychological and physical harms posed by institutionalization have been recognized as irreparable and sufficient to justify injunctive relief. *See Marlo*, 2010 WL 148849, at *2; *Crabtree v. Goetz*, 2008 WL 5330506, at *30 (M.D. Tenn. Dec., 19, 2008). In this case, the State has utterly failed to give any deference to the opinions of Brook’s treating physicians, in violation of *Olmstead*, 527 U.S. at 610; *Crabtree*, 2008 WL 5330506.

In her Petition, Brook recited exigent circumstances, including evidence that she has quadriplegia, that she breathes through a tracheostomy and that her condition is life threatening if the services ordered by her physicians and ordered by the Hearing Officer are not provided. Petition at 1 and 2. Brook clearly and unambiguously informed the Court in that Petition exactly how she will suffer irreparable injury if this Court does not accept and rule upon her Petition

requiring DHHS to comply with the hearing officer's orders. Petition at 2. As evidence of irreparable injury, Brook informed the Court that she has "been plagued with recurrent infections, requiring lengthy hospitalizations, which likely could have been avoided if nursing and personal care attendant services ordered by her physicians had been provided." Petition at 2. She informed the Administrative Law Court that she has to be suctioned throughout the day and she is at risk of aspiration. Id. She also informed the Court that she now has seizures, which she never experienced when around-the-clock nursing services were provided in the hospital. Id. In addition, Brook informed this Court that she "has experienced periods of mental confusion which were not present before her release from the hospital in 2007, when these nursing services were being provided." Id.

Brook's mother, Sandra Waddle, has provided a sworn affidavit confirming the irreparable harm her daughter continues to suffer. Exhibit 4. After the last hearing at DHHS in 2012 Brook was again hospitalized for a serious infection, which had to be treated with strong antibiotic drugs. Id. It took four weeks to try to clear up the infection and her bowels were paralyzed due to the antibiotics she had to take. Id. This caused her to have to return to the hospital for one week after her bowels quit functioning properly. Id. These infections have caused Brook to have fevers and very bad cold sweats. This former cheerleader and homecoming queen resorted to having to shave her head to try to control her fevers. Id. According to Brook's mother, she was "out of her head because of the fever and her mental status has deteriorated due to the stress and constant infections she has suffered." Exhibit 4.

As predicted, Brook has experienced muscle contractures and spasms which are "really

painful,” requiring her to take strong medications to try to relieve the pain. Her mother, who still has not been paid for her services, as ordered by Judge McLeod of this Court in 2012, is “exhausted.” This places Brook at serious risk of institutionalization. Also as predicted, while in the hospital, Brook got a decubitus ulcer on her hip that took nearly four weeks to heal after a wound care specialist was brought in.

Although DHHS finally paid for the speech device ordered in 2007, Brook has not been provided the eye gaze speech device she needs to prevent further deterioration in her mental and physical condition. DHHS presented no conflicting evidence to challenge the opinion of the speech and language specialist who testified at her hearing. R. 477 to 487. Indeed, DHHS’ own expert testified that this device is covered by Medicaid and that persons with her conditions have received them. R. 454 to 470.

Perhaps what is most egregious is that DHHS still has not provided the RN services its experts agreed in 2012 that she needs. DHHS has failed to provide psychological services it acknowledged to be medically necessary. Exhibit 5. Affidavit of Lennie Mullis. Brook’s family has been “torn apart” by DHHS’ conscious disregard for her needs and she lives in “constant fear” of losing her battle to remain at home. Exhibit 4. Affidavit of Sandra Waddle.

Even the DHHS hearing officer’s order itself is replete with evidence of irreparable harm. The hearing officer found that Brook “requires constant care and cannot be left alone.” R. at 26. In the Order, the hearing officer found that “The Respondent has not provided any records which indicate that a physician for the Respondent has ever reviewed the Petitioner’s medical needs.” Id. Respondent acknowledged the need for services to be provided by a Registered Nurse, which

have not been provided since they were ordered by her physician in 2007. R. at 14. ("The Petitioner has never received ongoing RN care at home." R. 15.) Brook has to be suctioned throughout the day to prevent aspiration and "a mucus plug in her tracheostomy tube could be deadly without a nurse or the Petitioner's mother there to suction." R. at 16. She cannot breathe when she gets a mucus plug and there is no forewarning as to when this happens. Brook's trach must be cleaned "frequently." Id. Only a nurse or Brook's mother can reinsert her catheter if it comes out. R. at 17. She has had "frequent bouts with pneumonia which require suctioning as much as 3-5 times per hour" and has "suffered from frequent urinary tract infections." Id. Because of contractures, Brook cannot straighten her arms and her skin will break if her arms are stretched. Id. She has not received the physical therapy services she needs, because her mother is too exhausted to take her and DHHS terminated physical therapy services from the Medicaid waiver package.³ Id. She has painful kidney stones and takes medications for seizures, depression, bowel movements, neuropathy pain, muscle spasms and migraine headaches. Id. She has suffered decubitus ulcers and is at risk of infection. R. at 18. She needs to have blood drawn to monitor blood levels, but nursing services necessary to perform this task have not been provided. Id.

Between January and August 2011, Brook suffered four seizures requiring hospitalizations and her physicians determined that the chronic urinary tract infections contributed to her seizures. R. at 20. She "required 3 or 4 hospitalizations due to chronic urinary

³ DHHS has claimed that these services are available through the "regular" State Plan services, but they have not been provided. DHHS offered to restore these services, only upon the condition that Brook accept a settlement containing fewer hours than her physician has ordered.

tract infections” during this time. Id. Brook suffers from depression and anxiety and had to be hospitalized for “confusion and altered mental state.” Id. She requires “continued monitoring” and turning to prevent decubitus ulcers. R. at 21. Brook’s inability to communicate delays her getting timely care. Id. She is “frightened by the grand mal seizures that she has suffered.” R. at 23.

The hearing officer found that Brook should receive “the maximum services available under the HASCI Waiver” and that she has only been able to remain at home “due to the extraordinary efforts and dedication of her mother.” R. at 26 and 27. However, she ruled that “an Administrative Hearing Officer does not have the authority to exceed the limits of the Waiver program.” R. at 33. It is clear from that order that the hearing officer intended for the services to be continued during the appeal in this Court, but DHHS has ignored the order and refuses to provide these services and the payment to Sandra Waddle. (DHHS did pay the amount awarded for the speech device.)

(2) *Brook is likely to prevail on the merits.*

The DHHS hearing officer ruled that Brook prevailed on the merits of her appeal and ordered DHHS to provide the services her physicians ordered in 2007 pending the final resolution of her appeal. She also ordered DHHS to pay Sandra Waddle more than \$140,000 for her services rendered prior to the order, in addition to \$11.10 an hour (plus any increase paid to other attendant caregivers) for services going forward.

This Court has repeatedly ruled that the caps on services that are an issue in this case are unenforceable. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0656-AP (S.C.A.L.C. July 19, 2011)

and *Edge, Eubanks, Morgan and Myers v. DHHS*, Docket No. 10-ALJ-08-0504 (S.C.A.L.C. 2011).

In *Peter B. v. Sanford*, the federal district court addressed the issue of whether three Medicaid waiver participants were likely to prevail on the merits. *Supra*. The magistrate judge found that:

Title II of the Americans with Disabilities Act of 1990 (ADA), prohibits discrimination by public entities against individuals with disabilities. *See* 42 U.S.C. § 12132. The United States Supreme Court has held that prohibited discrimination under the ADA includes “unnecessary segregation” and “unjustified institutional isolation of personal disabilities.” *Olmstead v. L.C.*, 527 U.S. 581, 600-02 (1999). The Supreme Court’s determination was based, in part, on the Department of Justice regulation, usually referred to as the “integration mandate,” which requires states to administer services “in the most integrated setting appropriate to the needs of the qualified individuals with disabilities.” 28 C.F.R. § 35.130(d) (amended at 75 F.R. 56164-01, adding a section “h” to § 35.130). The most integrated setting appropriate is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.” *Olmstead*, 527 U.S. 581, 592 (citing 28 C.F.R. pt. 35, App. A. p. 450, redesignated App. B at 75 F.R.56164-01). In other words, it is discrimination, on account of a person’s disability, to create obstacles to their ability to live normally in their community.

CMS has recently issued its final rule interpreting the requirements of the *Olmstead* decision and the provision of services in the least restrictive setting which are located at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>. Brook has demonstrated that she has been segregated and terribly isolated due to DHHS failing to provide the services ordered by her physicians and her chosen provider of psychological services and Defendants have failed to present contradicting evidence. She has suffered lengthy stays in the hospital and is at serious risk of institutionalization.

Once Brook demonstrated that she is a disabled person, that she chooses to remain in the

community and the State has determined that her needs can be met in the community,⁴ the burden then shifted to the State to prove that providing the services Brook's physicians have ordered would cause a "fundamental alteration" in the State's system. The State has failed to meet that burden. The hearing officer found that DHHS failed to conduct cost studies or to even consider the opinions of her treating physicians before reducing her services.

The hearing officer addressed the issue of what services must be provided during the pendency of this appeal. She ruled that Brook should have received 84 hours a week of LPN services and 28 hours a week of RN services, which should have been "continued through the final result of this appeal." R. at 33. This is not a case where the parties disagree about whether the waiver participant can be left alone. Brook's physicians ordered, and everyone agrees that she requires care from her mother at any time when a nurse is not present.

The medical director of DHHS testified that the decision to deny the services Brook's physicians ordered was based "upon Department guidance and the SCDHHS provider manual policy," not on Brook's medical condition. R. at 19. As the magistrate judge noted in *Peter B. v. Sanford*, in *Olmstead v. L.C.*, the United States Supreme Court ruled that:

The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.

Peter B. v. Sanford. Exhibit 6.

⁴ The hearing officer found that "Community-based treatment is appropriate for the Petitioner and she seeks to continue community-based care." R. at 23.

The hearing officer clearly held that the reductions at issue in this appeal were made without complying with the notice requirements of the Medicaid Act. 42 C.F.R. 431.210 and *Goldberg v. Kelly*, 397 U.S. 254 (1970). R. at 27. DHHS took the extraordinary action of asking its own employee to reconsider her opinion by filing a Rule 59 motion, which was denied. Exhibit 2. She clearly ordered DHHS to provide the services ordered by Brook's physicians during the pendency of this appeal. The hearing officer ordered DHHS not to reduce Brook's services without notice and an opportunity for a hearing - yet that is exactly what DHHS proceeded to do. R. at 33. In *B.W. v. DHHS*, DHHS refused to pay for a replacement oximeter cable and when she objected to the defective notice and due process, DHHS and this Court dismissed her appeal without providing a fair hearing. 13 ALJ-08-0267-AP. This appeal is pending in the South Carolina Court of Appeals now, more than a year after her need for this critical equipment was made known to DHHS. *B.W. v. DHHS*, Case No. 2013-002415. The futility of state administrative proceedings is demonstrated by the fact that DHHS forced Brook into an appeal to the Court of Appeals after refusing to provide a fair hearing when payment for this inexpensive, but life saving device was denied. (This appeal is now pending in the South Carolina Court of Appeals.)

The arbitrariness of the agency's actions are demonstrated by Respondent's own actions, which contradict the agency's claims that DHHS cannot exceed the caps established in 2010. The Respondent offered to provide services in an amount that is in excess of the caps just prior to the October 2012 hearings, yet at a rate below the number of hours all parties agree that she needs (24 hour supervision). R. at 33. This was an "all or nothing deal," leaving Brook with the same

inadequate services she was receiving when the hearing began. It is clearly arbitrary and capricious for DHHS to argue in this appeal that these caps cannot be exceeded, while agreeing to exceed them - but only to the level of services provided when Brook filed this appeal in 2007. Based on the totality of the circumstances in this case and the unenforceability of the caps, it is likely that Brook will prevail on the merits on appeal from the DHHS decision.

The Medicaid Act requires DHHS to provide services with "reasonable promptness." 42 U.S.C. 1396a(a)(8). The Fourth Circuit has interpreted this to mean within 90 days:

Section 1396a(a)(8) of the Act requires that state "medical assistance ... be furnished with reasonable promptness to all eligible individuals." Federal regulations direct state agencies to determine an applicant's eligibility for Medicaid **within ninety days** of the date of application and to "[f]urnish Medicaid promptly to recipients without **any delay caused by the agency's administrative procedures**." 42 C.F.R. §§ 435.911, 435.930 (2002).

(Emphasis added.) *Doe v. Kidd I*, 501 F.3d 348, 351 (4th Cir. 2007). More than seven years after this appeal was filed requesting additional services, not only has DHHS repeatedly reduced Brook's services without notice required by federal regulations, but the State has never caused her to be evaluated by a qualified medical source. R. at 18. DDSN's "centralized nurse," who has never met Brook, has determined how many hours she needs and DHHS admitted that this nurse does not consider the level of services ordered by Brook's treating physician in making treatment decisions. R. at 18 and 19. Brook has been mired in the same "bureaucratic gobbledegook having no relation to her actual condition or need" that the district court described in *Moore v. Cook*, Civil Action File 1:07-CV-631 (N.D.Ga. April 19, 2012). In *Moore*, our sister State of Georgia reduced a Medicaid waiver participant's nursing services from 94 hours a week

to 84 hours a week. In that case, the decision to reduce nursing hours was made by a physician hired by the agency to make medical necessity reviews one day a week, applying standards established by the state agency. As in *Moore*, Brook has provided "voluminous medical records," to support the medical necessity for the services he has requested and the State's "experts" have failed to refer to any "contemporaneous records" to support the decision to reduce and deny those services. *Id.*

(3) *There is no adequate remedy at law.*

DHHS has repeatedly informed the federal courts that the only remedy available to a Medicaid participant is the "fair hearing" process through DHHS and this Court. *Doe v. Kidd I and Doe v. Kidd II*, Case No. 1091 (4th Cir. 2011) and *Peter B. v. Sanford, R&R, supra*. They have advised those courts that services are maintained through a final decision being rendered by the Administrative Law Court, yet DHHS repeatedly reduced Brook's services while this appeal was pending and the agency's own hearing officer found that they violated her due process right to notice before implementing those reductions. Due to the severity of her condition and need for immediate relief, Brook reserves the right to file a Petition in the South Carolina Supreme Court pursuant to Rule 245 of the South Carolina Appellate Court Rules should the relief in this Petition/Complaint not be granted promptly.

CONCLUSION

In her Petition, Brook recited that S.C. Code Ann. § 1-23-630, which provides that "Each administrative law judge of the [ALC] has the same power at chambers or in open hearing as do

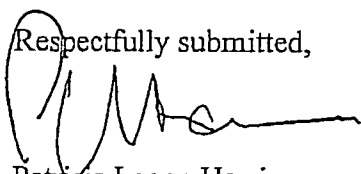
circuit court judges and to issue those remedial writs as are necessary to give effect to its jurisdiction." (2005) (emphasis added). This power is in addition to the power to hold DHHS in contempt and enforcement of Hearing Officer Hutto's order does not require a finding of willful contempt. (Although Appellant believes that a contempt order is appropriate in this case.)

As Brook requested in her May 1, 2014 Petition:

This Court should enforce the Orders of this Court and the DHHS Hearing Officer, requiring DHHS to immediately provide the services ordered by Brook's physician and to promptly pay the amount the DHHS Hearing Officer found due, pursuant to Judge McLeod's Order, to her mother pursuant to the order of Judge McLeod.

Id. DHHS has been clearly on notice of her request to enforce Hutto's orders.⁵ There could be no prejudice to DHHS if this Court were to immediately, without a hearing, order the agency to provide the services required by Hutto's order. Brook requests that the Court immediately order, during the pendency of this appeal, DHHS to provide the services ordered by Dr. Silvestri in 2007 and to pay the amount ordered to Sandra Waddle for the exceptional services she has rendered. Appellant also prays for an award of legal fees and costs.

Respectfully submitted,



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June 20, 2014

⁵ It is ironic that DHHS complains that the agency would be prejudiced at the June 12, 2014 hearing by this Court considering her Petition to require the agency to comply with the orders of its own hearing officer, because it is uncontested that DHHS illegally reduced her services during this appeal without complying with the clear and unambiguous notice requirements contained in 42 C.F.R. 431.210.

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

VERIFICATION

I, Brook Waddle, being duly sworn upon my oath, depose and say that I have subscribed to the foregoing Petition/Complaint; that I know the contents thereof; that it includes grounds for lifting any stay imposed by the appeal to this Court; and that the matters and allegations contained in the Petition/Complaint are true. Executed this 20th day of June, 2014.

Brook Waddle

Brook Waddle

Sandra Waddle

Sandra Waddle, Attorney in Fact

SWORN TO BEFORE ME THIS

20 day of June, 2014.

[Signature]

Notary Public for South Carolina

My Commission Expires

LIST OF EXHIBITS

1. November 19, 2013 Order of DHHS Hearing Officer Hutto
2. December 23, 2013 Order of DHHS Hearing Officer Hutto
3. May 1, 2014 Petition filed by Appellant in ALC
4. Affidavit of Sandra Waddle
5. Affidavit of Lennie Mullis
6. Peter B. v. Sanford, Report and Recommendation of Magistrate Judge
7. South Carolina Administrative Practice and Procedure Excerpt
8. *"To Stay or Not to Stay: Automatic Stays Before the Administrative Law Court in DHEC Matters,"* published in the September 2008 South Carolina Lawyer
9. November 2008 Letter from CMS to DHHS approving waiver costs
10. November 2009 Letter from CMS to DHHS approving waiver costs

Exhibit 7

Richard Stogsdill et al v. Sebelius et al

3:12-cv-00007-JFA

Entry No. 103:

Plaintiffs' Motion for Partial Summary Judgment

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

COLUMBIA DIVISION

Civil Case No. 3:12-cv-00007-JFA

Richard Stogsdill, Nancy Stogsdill, Mother of
Richard Stogsdill; Robert Levin, and Mary Self,
Mother of Robert Levin,
Plaintiffs

v.

Anthony Keck and the South Carolina
Department of Health and Human Services,
Defendants.

PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT

NATURE OF THE CASE

This lawsuit challenges the policies and practices of the Defendants in the operation of two Medicaid programs, the Head and Spinal Cord Injury (HASCI) Medicaid waiver program and the Intellectual Disabilities/Related Disabilities (ID/RD) Medicaid waiver program.¹ In the Second Amended Complaint, the Plaintiffs alleged violation of (1) statutory and Constitutional due process rights; (2) violation of the South Carolina Administrative Procedures Act; (3) violation of the Americans with Disabilities Act; (4) violation of Section 504 of the Rehabilitation Act; (5) violation of the Medicaid Act and the Supremacy Clause; and (6) violation of § 1983 the Civil Rights Act. Plaintiffs alleged that these violations are ongoing and they are subject to repetition, yet they have evaded review.

¹ When this lawsuit was filed, this program was called the Mental Retardation/Related Disabilities (MR/RD) program, but the term "mental retardation" has been replaced in state and federal law with "intellectual disabilities." The definition of the two terms is identical and the eligibility criteria has not changed as a result of this change in language.

LEGAL STANDARD

Summary judgment is appropriate where "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(a). The moving party has the initial burden of demonstrating that summary judgment is appropriate. Then the burden shifts to the non-movant to set forth specific facts showing that there is a genuine issue for trial. See *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 23 (1986). The movant must support the motion by "citing to particular parts of materials in the record, including depositions, documents, electronically stored information, affidavits or declarations, stipulations (including those made for purposes of the motion only), admissions, interrogatory answers, or other materials;" or "showing... that an adverse party cannot produce admissible evidence to support the fact." Fed.R.Civ.P. 56(c)(1).

To prevail on a motion for summary judgment, Plaintiffs must demonstrate that: (1) there is no genuine issue as to any material fact; and (2) that they are entitled to judgment as a matter of law. As to the first of these determinations, a fact is deemed "material" if proof of its existence or non-existence would affect disposition of the case under applicable law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Where the evidence offered shows that a reasonable jury might return a verdict for the non-movant, the fact is "material." *Id.* at 257.

The existence of a mere scintilla of evidence in support of the non-movant's position is insufficient to withstand the summary judgment motion. *Anderson*, 477 U.S. at 252. Likewise, conclusory allegations or denials, without more, will not preclude the granting of the summary judgment motion. *Ross v. Communications Satellite Corp.*, 759 F.2d 355, 365 (4th Cir. 1985). "Only disputes over facts that might affect the outcome of the suit under the governing law will

properly preclude the entry of summary judgment. Factual disputes that are irrelevant or unnecessary will not be counted." *Anderson*, 477 U.S. at 248.

The Court may grant summary judgment to a movant or a nonmovant, grant the motion on grounds not raised by a party, or may give an opportunity to properly support or address a fact not properly supported in the party's motion or memorandum. FRCP 56(e) and (f).

In order to prove a violation of the Americans with Disabilities Act (ADA), the plaintiffs must demonstrate that (1) they are qualified persons with disabilities, (2) the State has determined that community based treatment is appropriate, and (3) they do not oppose receiving services in the community instead of an institutional setting, and (4) that the services they seek can be reasonably accommodated, taking into account the resources available to the State and the needs of others with disabilities. *Olmstead v. L.C.*, 527 U.S. 581, 607 (1999). At that point, the burden shifts to the defendants to prove that the requested services would cause a fundamental alteration in the State's programs. *Olmstead* at 603 and *Frederick L. V. Dep't of Pub. Welfare of Pa.*, 422 F.3d 151 (3rd Cir.). The State must then demonstrate that "the requested relief would require an unduly burdensome or fundamental alteration of state policy in light of its economic resources..." *Id.* at 492, n.4.

BACKGROUND

Richard S.

Richard S. filed an administrative appeal on February 13, 2009, requesting a "fair hearing," as authorized by 42 U.S.C. 1396a(a)(3) when he graduated from high school and needed to replace the hours of services that had been provided by the State in the school. Entry 72-1. His mother worked a number of part time jobs and his father, who has since died, traveled

in his work. Richard's father died in 2013 after a long and serious illness. Exhibit 24. Richard alleged that DHHS failed to provide medically necessary services and that it failed to act with reasonable promptness. 42 C.F.R. 431.200 et. seq. and S.C. Code Regs. 126.380.² On March 3, 2009 DDSN issued a decision denying Richard's request for reconsideration, determining that there had been "no suspension, reduction, or termination" of Richard's services. Richard appealed this decision to DHHS on April 1, 2009. A hearing was held and, nine months after Richard filed his appeal. At this hearing, Richard submitted an affidavit prepared by Lennie Mullins, his provider of psychological services, in support of his need for additional hours. Exhibit 25. A few weeks later, DHHS terminated Ms. Mullis' certification as a provider of Medicaid waiver services.³ Id. Exhibits 11 and 12.

The DHHS hearing officer issued an interlocutory order on November 16, 2009, remanding Richard's case to DDSN. Richard's DDSN service coordinator informed Richard's

² S.C. Code. Regs. § **126-380. Denial, Termination, or Reduction of Benefits** provides that:

A. When an individual's Medicaid benefits are denied, discontinued or changed, the individual shall receive notice pursuant to Title XIX of the Social Security Act. The notice shall include an explanation of the individual's right to a fair hearing, the method to obtain a hearing, and the right to representation.

B. Fair hearings shall be conducted pursuant to R. 126-150.

C. An individual's Medicaid benefits may be continued pending a fair hearing decision in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

³ This was the second time DHHS, in conjunction with DHHS, terminated Mullis' certification, but both times their decisions were reversed by the Administrative Law Court. Exhibits 11 and 12. Lennie Mullis v. DHHS I and Lennie Mullis v. DHHS II. According to an affidavit signed by Ms. Mullis families and providers are fearful of retaliation when they challenge DDSN or DHHS. Exhibit 25.

guardian that his PCA and Respite hours would be reduced effective January 1, 2010, below the number of hours he was receiving when he filed the 2009 appeal requesting additional services. He was not provided with written notice meeting the requirements of 42 C.F.R. 431.210.

On December 30, 2009, Richard's counsel filed a request with DDSN for reconsideration of its decision to reduce his services and he again requested a fair hearing. In this appeal, he requested compliance with the November 16, 2009 Order of the DHHS Office of Hearings and Appeals and reconsideration of the decision to reduce and cap his services. Richard also requested reconsideration of the decision to terminate his right to receive Physical Therapy, Occupational Therapy and Speech and Language Services. Richard restated the complaints contained in his 2009 appeal.

On January 11, 2010, Richard's DDSN service coordinator sent Notices of Termination of all of Richard's PCA Services and Specialized Medical Equipment, Supplies and Assistive Technology to the providers of those services.⁴ These notices were not provided to Richard or his attorney, only to the providers.⁵ The reason for the termination of these services was "Participant moved out of state." Id. Richard has not moved from his home.

⁴The official at DHHS responsible for the ID/RD Medicaid waiver program admitted that the notices provided to waiver participants affected by these cuts did not meet the requirements of 42 C.F.R. 431.210. Exhibit 28, page 60, line 1 to page 61, line 12. On December 23, 2009, Richard and other affected waiver participants petitioned the South Carolina Supreme Court objecting to the planned reductions in Medicaid waiver services, requesting that the Court hear their Petition in its original jurisdiction. Richard requested an injunction to prohibit DDSN and DHHS from implementing these caps which were scheduled to take place on January 1, 2010. The Supreme Court denied Richard's Petition for original jurisdiction, without ruling on the merits of the case.

⁵ The problem of sending notices of denial to providers instead of Medicaid participants is systemic and is discussed in the B.W. order at Exhibit 22.

Richard appealed the following issues to the DHHS Office of Hearings and Appeals in February of 2010:

1. Improper reduction of waiver services, including, but not limited to PCA, Adult Companion Services and Respite Services.
2. Termination of daily respite as a waiver option.
3. Termination of speech and language, physical therapy and occupational services.
4. The State's failure to apply reasonable medical standards to determine medical necessity.
5. Violation of Richard's right of due process, including, but not limited to, the failure to provide proper notice and to determine eligibility for services with reasonable promptness.
6. Failure to determine eligibility for and to provide medically necessary services prescribed by Richard's treating physician.
7. Failure to provide services in the least restrictive setting pursuant to the mandates contained in *Olmstead*.
8. Failure to spend federal stimulus funds to maintain waiver participants' services.

Exhibit 31 at 2. A hearing was held on May 11, 2010 at DHHS and the hearing officer issued an Order on September 14, 2010, acknowledging that DDSN failed to provide proper notice, without providing a remedy for this ongoing violation of due process rights. Exhibit 31. The Hearing Officer determined that the November 19, 2009 Order (which was an unappealable interlocutory order) was superceded by the "intervening factor of the new Waiver with new limits." *Id.* The Order determined that Respondent acted lawfully in implementing the January 1, 2010 caps and in terminating Physical Therapy, Occupational Therapy and Speech and Language Services. The Hearing Officer summarily dismissed Richard's claims that DHHS violated *Olmstead*, but he ruled that "those legal arguments may be preserved for further review." He ruled that the November 16, 2009 order of DHHS Hearing Officer Loomis was not binding on him or the agency and his order dismissed Richard's claims of violation of the Medicaid Act and the American Recovery and Reinvestment Act. *Id.*

Richard filed an appeal in the South Carolina Administrative Law Court on October 20, 2010. While this appeal was pending, in January of 2012, Richard joined Rob and their mothers to file this lawsuit in the federal district court against the Director of the U.S. Department of Health and Human Services, DHHS and its State Director, Anthony Keck. *Richard S. v. Sebelius*, Case No. Civil Case No. 3:12-cv-00007-TMC (D.C.S.C.). In this federal action, Richard alleged violations of the Americans with Disabilities Act (hereinafter referred to as the “ADA”), Section 504 of the Rehabilitation Act (hereinafter referred to as “Section 504”), the Medicaid Act, the Administrative Procedures Act of the State of South Carolina and both the Supremacy and Due Process Clauses of the United States Constitution.

The United States Department of Justice was dismissed after its attorney took the position that the federal government was not a necessary party to enforce Plaintiffs’ rights under the ADA and the Medicaid Act in the federal courts. Exhibit 4. See also Motion filed by DOJ stating that CMS enforcement does not prevent private enforcement.

The South Carolina Administrative Law Court issued an order on Richard’s administrative appeal on March 13, 2013, without oral argument, upholding Hearing Officer Bryson’s decision. Entry 58-4. The Administrative Law Judge ruled that the waiver amendments were lawfully made, services were provided with reasonable promptness, the *ex parte* communications Richard complained of were proper and that due process was afforded to Richard. The Administrative Law Court ruled that the November 16, 2009 Order was a final order that was “carried out while confirming with the changes in the Waiver.” *Id.* The Administrative Law Judge denied Richard’s claims brought under the ADA, ruling that those were “speculative” and that the State’s responsibilities under *Olmstead* are not “boundless.” The

order did not discuss whether providing the relief Richard requested would “fundamentally alter” the State’s programs. Id.

On April 9, 2013 Richard filed an appeal of this then more than six year old state administrative appeal with the South Carolina Court of Appeals. An amicus brief was filed by Protection & Advocacy for Persons with Disabilities, South Carolina Legal Services, Appelseed and the South Carolina Chapter of the National Academy of Elder Law Attorneys. Exhibit 14. Oral arguments were heard in the Court of Appeals in March, 2014, but a decision has not been issued.

While his case was pending in the Court of Appeals, however, the DHHS Office of Hearings and Appeals issued a decision in another administrative appeal case filed by a HASCI waiver participant in 2007 which demonstrates the futility of efforts to obtain relief in the “fair hearing” process. *B.W. v. DHHS*. November 19, 2013. See Exhibits 22 and 23. Most importantly, the hearing officer ruled that DHHS hearing officers do not have the authority to exceed waiver caps. Exhibit 22. In that order, the hearing officer also ruled that DHHS had provided defective notices, or reduced services with no notices at all while B.W.’s appeal was pending. Id. She ruled that determinations of medical necessity were made by persons not qualified and ordered DHHS to provide the number of hours of services that had been ordered by Brook’s treating physician. Id. When DHHS refused to comply with this order of its own hearing officer, B.W. filed a Petition asking the Administrative Law Judge to enforce the order. Exhibit 21. In response, DHHS recently filed a Motion to Dismiss B.W.’s petition for a remedial writ, taking the position that the Administrative Law Court was without statutory authority to enforce an order of the DHHS hearing officer. Exhibit 32.

Rob L.

Rob L. Was injured while working as a photographer in New York City when he fell from a truck taking picture of Ground Zero in 2001. Exhibit 29. He was a thirty year old graduate of the Savannah College of Arts and Design. Until Rob's injury, his mother worked as an RN at the Columbia Free Clinic. Rob's mother has not been able to work since his injury. Rob spent approximately 4 months in the hospital in New York and forty nursing homes in the State of South Carolina refused to admit him because of the severity of his injuries. He was on a ventilator, using a trach and he was in a vegetative state. Rob's mother wrote to Senator Strom Thurmond, Representative Joe Wilson and the Governor pleading with them to help her bring her son home to South Carolina.

Rob's mother attempted to obtain services through the HASCI waiver, but DDSN would not provide sufficient hours to support him to return home. Id. Finally, Anna Maria Nursing Home in North Augusta agreed to accept Rob and he was transferred there on April 6, 2002 and remained there for four years. His mother visited Rob nearly every day and she later hired someone to visit him on weekends, because she was exhausted from traveling 150 miles round trip each day.

When Rob returned home in 2006, DHHS was only providing 8 hours a day of personal care attendant services and the caregiver was paid only \$8.00 an hour. Id. It was difficult to retain caregivers at that low rate of pay and turnover was a problem. In 2009, DDSN told Rob's mother that his attendant care services were being cut from 8 hours a day to 7 hours a day due to budget reductions that were across the board and affected everyone. Id. No one informed Rob's mother that he had the right to appeal this reduction and that other HASCI waiver participants were

receiving more services.

Rob's caregivers had come from an agency, but then DDSN told his mother that if he used UAP (University (of South Carolina) Attendant Program) the same attendants would be able to work with Rob, but they would be paid \$11.00 an hour. DDSN never told her that the State would then treat her as the employer of record or that she might be liable if the caregiver was injured on the job because DDSN was not providing Worker's Comp on under the UAP program. In fact, DDSN told her that it would not be necessary for Rob to provide Worker's Compensation for the caregivers if he made this change.

After this raise in pay, there has been significantly less turnover and better quality caregivers. The caregiver sends the timesheet to Jasper County and to Richland Lexington DSN Board. Somehow, the Medicaid funds go from DHHS to DDSN were then to Jasper County DSN Board, which paid the caregiver. UAP did a background check and decided whether or not to hire candidates for the job and caregivers cannot be hired without their approval.

When one of Rob's caregivers was injured on the job in 2012, she sued Rob's mother after UAP and the DDSN agencies involved refused to provide Worker's Compensation coverage for her injuries. The Richland Lexington DSN Board, Jasper County DSN Board and UAP all denied that they were the employer and denied being liable for Worker's Compensation. Worker's Comp eventually determined that Rob's mother was not the employer of record and ruled against the agencies, but she was forced to spend more than \$12,000 out of her own pocket in legal fees defending herself against these charges. Then, the caregiver sued Rob's mother personally, because the agencies still refused to pay the caregiver the Worker's Comp award.

Rob's mother described the stress of this litigation over the caregiver's injury as being

“insurmountable” and it interferes with her sleep. Id. She worries about it all the time. Her blood pressure has been high and the “anxiety has been tremendous.” Id. Her whole life has changed and she is fearful of losing everything she has worked to build all her life. According to Rob’s mother, the stress caused by the State’s failure to provide Worker’s Comp “has made it more difficult to provide the care that Rob needs.”

Rob’s mother has to provide medications to Rob through a tube in his stomach at 5 a.m., 7 a.m., 9 a.m., 12 noon, 2 p.m., 6:30 p.m. and again at 8 p.m. Rob is fed through the night, so she has to be available at all times in case the machine malfunctions. She sleeps with a monitor by her bed. The attendant cannot provide any of these administrations of medicine or tube feedings and Rob’s DDSN service coordinator never told her that Rob could get any nursing services to get his mother some relief. The service coordinator told Rob’s mother that she would have to go into a nursing home in order to get respite services, but she believes that going back into a nursing home would be devastating to Rob and he would injure someone because he gets so violent when he is stressed. The nursing home would have to super sedate him to keep Rob calm.

No one ever told Rob’s mother that he might be entitled to receive a speech device that would allow him to communicate and that these devices are covered by Medicaid. She was informed in 2010 DDSN eliminated speech, physical and occupational therapies due to budget reductions. Id.

Due to the reductions and the way DDSN limits use of allocated hours, if anything happened to Rob’s mother, like breaking an arm or having an illness, there is no one who could take care of Rob at home. Id. When Rob gets upset, he pulls his tubes out and someone has to be there all the time. He needs to have nursing services 8 hours a day and he needs attendant care 16

hours a day when nursing services are not provided. Rob's mother is 64 years old and she has severe arthritis and "needs help now."

ISSUE #1 Violation of Statutory and Constitutional Due Process and Civil Rights

(Causes of Action Numbers 2 and 6)

Plaintiffs request summary judgment on their claims for violation of due process under Section 1983. The Due Process Clause of the Fourteenth Amendment to the United States Constitution prohibits states from denying, reducing or terminating services without due process of law. The Fourteenth Amendment provides that a state shall not "deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. Pursuant to § 1983, a claim alleging a denial of procedural due process requires proof of three elements: (1) a deprivation of a constitutionally-protected liberty or property interest; (2) state action; and (3) constitutionally-inadequate process." *Grayden v. Rhodes*, 345 F.3d 1225, 1232 (11th Cir.2003). The Constitutional right to due process includes the right to meaningful notice prior to the termination or reduction of Medicaid benefits and a fair and impartial pre-termination hearing. *Goldberg v. Kelly*, 397 U.S. 254 (1970).

States that participate in Medicaid 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). *Brown v. DHHS*, 393 S.C. 11, 709 S.E.2d 701 (S.C.App. 2011). Federal regulations specifically incorporate the requirements set forth in *Goldberg* in the Medicaid regulations. 42 C.F.R. 431.205(d). Under the United States Supreme Court's holding in *Goldberg*, recipients of government benefits are entitled to timely, adequate, and understandable written notices of their hearing rights, and a

hearing that is fair and impartial and held at a meaningful time. The written notice of reduction, termination or denial of Medicaid benefits must meet explicit requirements set forth in 42 C.F.R. 431.210, including specifying the reasons for the adverse action and identifying the statute or regulation the state relied upon.

Except in limited circumstances, eligibility for the requested services must be ruled upon within 90 days. 42 C.F.R. 431.244(f). *Doe v. Kidd I*, 501 F.3d 348, 356 (4th Cir. 2007) (“...federal and state regulations and manuals define reasonable promptness as forty-five days or ninety days, depending on the applicant. *See, e.g.*, 42 C.F.R. § 435.911”) and *Doe v. Kidd II*, Case No. 10-1191, fn 2 (4th Cir. 2011). The Act requires that Medicaid services must actually be provided with reasonable promptness, and a simple promise to provide services does not meet that standard. 42 U.S.C. 1396a(a)(8). *Doe v. Kidd, I and II, supra*.

The due process requirements under the Medicaid Act were discussed and interpreted by the United States Court of Appeals in *Shakhnes v. Berlin*. 689 F.3d 244 (2nd Cir. 2012). In that case, the United States Court of Appeals for the Second Circuit held that the regulation “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 ‘[o]rdinarily, within 90 days’ of their request, *see* 42 C.F.R. § 431.244(f).” *Id.* at 254. The Second Circuit began its analysis with a review of 45 C.F.R. § 205.10, which was the predecessor to 42 C.F.R. § 431.244. Section 205.10 of that regulation was entitled “ Fair hearings.” *See* Fair Hearings, 35 Fed.Reg. 8448 (May 29, 1970). In Subsection (11) of § 205.10, the federal Medicaid agency provided that “ [p]rompt, definitive and final administrative action will be taken within 60 days from the date of the request for a fair hearing, except where the

claimant requests a delay in the hearing." *Id.* at 8449. The definition of "[p]rompt, definitive, and final administrative action" was later extended to 90 days. *See* Methods for Determination of Eligibility, 38 Fed.Reg. 22,005, 22,008 (Aug. 15, 1973). In doing so, the federal Medicaid agency explained that: "In view of the difficult position facing States with *substantially increased hearing caseloads*, the 60-day period is considered insufficient *for the orderly processing of cases*." *Id.* at 22,006 (emphasis added). It concluded that "[n]inety days for *processing hearings*" was "a more realistic time frame" and the change was described as an "[e]xtension from 60 to 90 days *for hearing decisions*." *Id.* (emphasis omitted).

As the Second Circuit noted in *Shaknes*:

Later agency commentary similarly referred to the 90-day requirement in § 431.244 as a deadline for the issuance of hearing decisions. *See, e.g.,* Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed.Reg. 40,989, 41,060 (June 14, 2002) (referencing "the 90-day clock for a fair hearing *decision*" (emphasis added)); *id.* ("[T]he State is required to *resolve the State fair hearing* within 90 days." (emphasis added)); *id.* at 41,064 (referencing "the overall 90-day timeframe for a final fair hearing *decision*" (emphasis added)); *id.* at 41,076 (referencing "the 90-day timeframe *for resolution of the State fair hearing*" (emphasis added)).

The Second Circuit recognized in that case that federal courts owe deference to the *State Medicaid Manual* issued by CMS. That manual clearly states that a remand "*is not a substitute for definitive and final administrative action*." *Id.* (emphasis added) (quotations omitted).

Section 2903.3 of the *State Medicaid Manual* — entitled "State Agency Responsibility In Carrying Out The Hearing Decision" — states that Defendants "are responsible for assuring that the [hearing authority]'s decision *is carried out promptly*." *Id.* § 2903.3(A). In *Doe v. Kidd I*, the Fourth Circuit agreed that "reasonable promptness" means less than 90 days. *Doe v. Kidd I*, *supra*.

This Court should note that the DHHS official responsible for the administration of the ID/RD Medicaid waiver program, Kara Lewis, did not know what “reasonable promptness” meant and did not seem to be aware that the Court of Appeals for the Fourth Circuit found in *Doe v. Kidd II* that DHHS had “abdicated” its responsibility to provide services to Doe with reasonable promptness. Exhibit 28 at pages 65 and 66. According to Ms. Lewis, it was “not an impediment to the work I do” to be ignorant of federal court cases and “we don’t have time to discuss these old cases.” *Id.* Director Keck was not at all familiar with *Doe v. Kidd* and did not know anything about the 90 day standard of promptness under the Medicaid Act. Exhibit 18 at 78, lines 25 to 78 and page 79 at 1 to 15. Deputy Director Pete Ligett, under whose supervision the DDSN waiver programs are operated also was unfamiliar with *Doe v. Kidd* or the reasonable promptness requirement of the Medicaid Act. Exhibit 15, Page 18, line 14 to 20. Another DHHS Deputy Director, Elizabeth Hutto, who has only been in the position a few months (formerly being a DHHS hearing officer) was somewhat familiar with the name of the case in *Doe v. Kidd*, but was not familiar with the Fourth Circuit’s holding in the case. Exhibit 16 at pages 48-49. She was aware that the Medicaid Act contained a “reasonable promptness” provision, but was unsure whether the 90 day requirement was a “hard and fast rule.” *Id.* at page 13.⁶

The Court of Appeals for the Third Circuit also addressed claimant’s due process rights in appeals of adverse actions in government benefits case in *Ortiz v. Eichler*, 794 F.2d 889 (3d Cir.

⁶ Plaintiff asserts that it is a tremendous waste of judicial resource, and taxpayer dollars when agency officials pay no heed to orders of the Court of Appeals for the Fourth Circuit. At the mediation in this case, DHHS did not send the Director of DHHS, who admits that he is the person responsible for making settlement decisions, or even a single executive official, only its lawyers. In Director Keck’s deposition, he states that it is his responsibility to decide to settle or appeal a case, but that this case (Stogsdill) was never brought to his attention. Page 67, lines 7 to 14.

1986). In that case, the claimants contended that the notices sent by the government were “inadequate because the notices failed to explain the reasons for DES's action or to present calculations justifying that action.” *Id.* 892. The district court had agreed with them and it directed the agency to issue notices that complied with the requirements of the applicable regulations and due process. Citing the leading case of *Goldberg v. Kelly*, 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970), the Court held that “due process requires that claimants facing termination of public assistance benefits must be given ‘adequate notice detailing the reasons for a proposed termination....’” *Kelly* at 267, 90 S.Ct. at 1020. This is the type of notice that is required to protect claimants against proposed agency action “resting on incorrect or misleading factual premises or on misapplication of rules to policies of the facts of particular cases.” *Id.* at 268, 90 S.Ct. at 1020. The Third Circuit found that “this requirement is amply supported by a formidable array of case law.” *Id.* at 893.

Richard’s request for additional services was made in February, 2009 and his appeal was remanded in November, 2009, without issuing a final, appealable order. On remand, instead of determining Richard’s need for additional services, DHHS sent a defective “notice” in December of 2009, informing him that DHHS intended to reduce his services even further based on the caps imposed in January 2010, which DHHS claimed to be due to budget reductions. No other reason for reducing Richard’s services was provided in the “notice.” This forced Richard into a second administrative appeal, or his hours would have been reduced based on these state-wide budget reductions. Richard was caught in the DDSN/DHHS/Administrative Law Court Executive Branch maze, until a final order was issued four years later and he finally was able to have his appeal heard by the Judicial Branch. But, the decision in *B.W. v. DHHS* demonstrates the futility

of state administrative appeals, because the DHHS Office of Hearings and Appeals has now ruled that hearing officers at DHHS do not have the authority to exceed the caps, not to mention that the attorney for DHHS has signed a motion to dismiss her petition for a remedial writ claiming that the Administrative Law Court does not have the authority to enforce an order of a DHHS hearing officer. Exhibits 21, 22, 32.

DHHS has flagrantly violated the due process and “fair hearing” requirements of the Medicaid Act and Plaintiff’s constitutional rights to due process. They have violated the federal requirement to issue a final state administrative decision within 90 days in other cases and these violations are subject to repetition. *Doe v. Kidd I and II, Supra*. In *Brown v. DHHS*, the Medicaid participant filed an appeal and requested a fair hearing in 2005. DHHS dismissed his appeal without providing a hearing on the merits of his case. Six years later, the South Carolina Court of Appeals reversed the agency’s decision and remanded Brown’s appeal to DHHS with instructions to provide a fair hearing. *Id.* Instead, DHHS again dismissed Brown’s appeal two years after remand, again without providing a fair hearing on the merits of his case.⁷ *Brown v. DHHS*, 393 S.C. 11, 709 S.E.2d 701 (S.C.App. 2011).

In *Doe v. Kidd*, the administrative appeals unending saga has lasted more than a decade, and she still has not been provided with the services contained in her 2003 plan of care.⁸ DHHS

⁷ Brown’s administrative appeal is being held in abeyance at the South Carolina Court of Appeals. Judge Michelle Childs ordered the agencies to restore his services in 2011 in *Peter B. v. Sanford*, but, according to his GAL, as of July, 2012, these services still had not been restored. Exhibit 33.

⁸ Just recently, DHHS has agreed to provide those services, but has refused to execute a written agreement ensuring Doe that the agency will comply with the Order of the Fourth Circuit. That case is on parallel appeals to the South Carolina Court of Appeals and the

dismissed Doe's administrative appeal in 2003, over her objections and without providing a fair hearing on the merits of her case, after DHHS promised to provide residential habilitation services. *Doe v. Kidd I, supra*. Doe became entangled again in state administrative appeals when DDSN determined in 2005 that she no longer qualified for the program. *Doe v. DHHS*, 398 S.C. 62, 727 S.E.2d 605 (S.C. 2011). Despite the 90 day standard of promptness for determining eligibility, Doe's eligibility for the program was not established by the DHHS hearing officer until 2013. Her appeal on the Administrative Law Court's denial of attorney fees is pending in the South Carolina Court of Appeals. *S.P. v. DHHS*, 2014-001284.

In March of 2011, the Fourth Circuit ruled that DHHS had violated Doe's right to receive residential habilitation services with reasonable promptness, finding that DHHS had "abdicated" its duty to provide those services and that Doe was the prevailing party entitled to legal fees. *Doe v. Kidd II, supra*. But DHHS continued to deny Doe's request to provide those services while her administrative appeal was pending, despite the Fourth Circuit ruling twice that the state proceedings were irrelevant to its decisions. *Doe v. Kidd I and Doe v. Kidd II, supra*.

In *B.W. v. DHHS*, a Medicaid participant who was rendered quadriplegic in a car accident in her senior year of high school filed a request for a fair hearing in 2007. The attached decisions of the DHHS hearing officer describes how DHHS reduced her services during her appeal in violation of CMS regulations, failed to provide notice meeting the requirements of 42 C.F.R. 431.210 and failed to provide services ordered by her physicians, without even obtaining an

Fourth Circuit. Three years after the decision of the Supreme Court in *Doe v. DHHS*, DDSN continues to apply the age 18 onset criteria for mental retardation/intellectual disabilities, in blatant violation of the Supreme Court's order that state law requires age 22 as the age of onset for the condition. *Doe v. DHHS*, 398 S.C. 62, 727 S.E.2d 605 (S.C. 2011). Exhibit 31.

opinion from a qualified examining medical source. Id. DHHS has refused to comply with this order, which is currently on appeal to the Administrative Law Court. Exhibit 21.

It is evident from the futile and wasteful administrative appeals Richard S. and his family have endured that DHHS has knowingly, blatantly and repeatedly violated the clear and distinct mandates set forth in CMS regulations on fair hearings and his right to procedural due process. 42 C.F.R. 431.200 et. seq., particularly, the requirements for content of notice (42 C.F.R. 431.210), the requirement that hearing decisions be based “exclusively” on evidence presented at a hearing (42 C.F.R. 431.244(a)) and the requirement to issue a final state administrative decision within 90 days of the request for the fair hearing (42 C.F.R. 431.244(f)). It is obvious from state administrative decisions that no corrective action has been taken, despite repeated violations.

Plaintiffs request summary judgment on the First Cause of Action for violation of due process. An order is respectfully requested requiring DHHS to comply with the Medicaid Act and CMS regulations by:

1. Requiring the agencies to provide written notices of adverse actions containing all of the information required by 42 C.F.R. 201.
2. Requiring DHHS to include in the notice the reason for the adverse action, and prohibiting the State from arguing any other grounds in support of its action at the hearing.
3. Prohibiting DDSN or DHHS from reducing the appellant’s services during an appeal.
4. Prohibiting DHHS from dismissing fair hearing appeals based on interlocutory orders without providing an evidentiary hearing meeting the requirements of 42 C.F.R. 431.200 et. seq. and *Goldberg v. Kelly, supra*.
5. Requiring a final administrative decision, appealable to the Judicial Branch, within 90 days of receipt of the request for a fair hearing.
6. Requiring agencies to base fair hearing decisions exclusively on evidence introduced at the evidentiary hearing, as required by 42 C.F.R. 431.244(a).
7. Prohibiting DHHS from extending the 90 day deadline by remanding the appeal.

8. Requiring DHHS to pay for all medically necessary services, as determined by the participant's physician, in cases where a decision is not reached within 90 days of the request for the appeal.
9. Retaining jurisdiction of this case and requiring DHHS to pay reasonable attorneys fees and costs.

ISSUE #2 Violation of the South Carolina Administrative Procedures Act (Second Cause of Action) and the Reasonable Standards mandate of the Medicaid Act (Fifth and Sixth Cause of Action).

Plaintiffs are entitled to summary judgment on this issue, because Defendants have clearly failed to establish and to apply reasonable standards and procedures in the operation of the Medicaid program and they have openly refused to promulgate regulations for the administration of Medicaid waiver programs. 42 U.S.C. 1396a(a)(17). *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013). In *P&A v. DDSN*, nine persons who have disabilities joined Protection & Advocacy for Persons who have Disabilities to file an action against DDSN simply requesting that the agency promulgate regulations. (DDSN operates the programs at issue in this case under contract with DHHS). After an unfavorable verdict in the circuit court, an appeal was taken to the South Carolina Court of Appeals, where the case is pending. See C Track at <http://ctrack.sccourts.org/public/caseView.do?csIID=55894> for copy of Appellant's initial brief.

This lawsuit was filed by Steve Hamm on behalf of the plaintiffs in 2007, but DDSN has stubbornly refused to promulgate regulations. Instead, DDSN manages the waiver programs at issue in this case based on "agency directives," which can be changed without review of approval of the General Assembly.⁹

⁹ One of these directives contains eligibility criteria to determine if a person has intellectual disabilities (formerly "mental retardation"). Despite the South Carolina Supreme Court ruling in *Doe v. DHHS* on December 28, 2011 that the age of onset contained in the

It goes without saying that in order to be “reasonable,” state agency standards must comply with both federal and state law. Any standard which does not comply with federal Medicaid statutes and regulations must be *per se* unreasonable. Unreasonable standards employed by the Defendants include the standard of allowing service coordinators to override the opinions of treating physicians. *Olmstead v. L.C.* 527 U.S. 589 (1999). As the Supreme Court ruled in that case:

It is of central importance, then, that courts apply today’s decision with great deference to the medical decisions of the responsible, treating physician...
 Id at 610. Justice Kennedy opined in *Olmstead* that “The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.” Id. According to testimony of Kara Lewis, the DHHS official in charge of the IC/RD Medicaid waiver program, DDSN service coordinators may override physicians’ orders regarding waiver services. Exhibit 28 at pages 63 and 64. It is obvious from the gross disregard for the opinions of treating physicians in this case that DHHS has made treatment decisions based on “bureaucratic gobbledegook having no relation to (Plaintiffs’) ~~her~~ actual condition or need.” *Moore v. Cook*, Civil Action File 1:07-CV-631 (N.D.Ga. April 19, 2012). In *Moore*, our sister State of Georgia reduced a Medicaid waiver participant’s nursing services from 94 hours a week to 84 hours a week. In that case, the decision to reduce nursing hours was made by a physician hired by the agency to make medical necessity reviews one day a week, applying

regulation promulgated by the General Assembly was age 22, not age 18. 398 S.C. 62, 727 S.E.2d 605 (S.C. 2011). DDSN has thrice revised this directive, still using the age 18 criteria, in complete disregard for the order of the South Carolina Supreme Court. See [http://ddsn.sc.gov/about/directives-standards/Documents/proposeddirectives/100-30-DD%20External%20Review%20\(081314\).pdf](http://ddsn.sc.gov/about/directives-standards/Documents/proposeddirectives/100-30-DD%20External%20Review%20(081314).pdf)

standards established by the state agency.

The official who testified that she is responsible for the administration of the DDSN waiver program, Kara Lewis, testified in her deposition that DHHS has no intention of promulgating regulations for the administration of the Medicaid waiver programs. Exhibit 28 at pages 54 and 55. She was unaware of the lawsuit P&A filed in 2007 asking DDSN to promulgate regulations for the programs DHHS supervises. *Id.* According to Ms. Lewis, the ID/RD Medicaid program is not based on a “medical model,” so that DDSN service coordinators do not have to give deference to opinions of treating physicians in allocating services. Exhibit 28 at pages 63 to 64.

In *Peter B. v. Sanford*, Judge Bruce Howe Hendricks discussed the importance of giving deference to the treating physician’s opinions:

The care the plaintiffs require is complicated, burdensome, and inexact. In some respects, there is no easy answer to their situations. But certainly, if anyone knows what might be the best, among many less than perfect alternatives, it is the plaintiffs, their families, and their physicians. To credit those accounts, earnestly, seems in keeping with the manner in which these cases are to be considered. *See Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring) (“The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.”) Case No. 6:10-767, Report and Recommendation of Magistrate, November 24, 2010 at 7. Entry 33-1.

In *Royal v. Cook*, the State of Georgia reduced nursing services in violation of the orders of the Plaintiff’s treating physician. Case No. 1:08-cv-2930-TWT (N.D.Ga. June 19, 2012). The district court held that the opinions of the State’s “experts” were “entitled to little weight.” The State’s physician had little recollection of what records he reviewed in reaching the decision to reduce Zachary’s nursing services. In rejecting the arbitrary caps established by the State of

Georgia, the court found that the treating physician's opinion as to medical necessity "is entitled to much greater weight" than that of the State's physicians who based their opinions on "summaries of his records." In *Royal*, the jury returned a verdict for the Medicaid waiver participant on both his Medicaid Act and ADA claims, and determined that he is entitled to permanent injunctive relief and a declaratory judgment prohibiting the Defendant from reducing his nursing hours below 18 hours a day. Entry 200. September 30, 2013.

A review of the State's own policies, statutes and regulations shows that the Defendants acted arbitrarily in establishing caps on services and that they have failed to establish reasonable standards. The DHHS policy that defines "medical necessity" states that:

Medicaid will pay for service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of the health or toward the diagnosis and treatment of illness or disability.

Entry 155-36 at 10. Reimbursement for covered services (which includes durable medical equipment) "is available for services that conform to accepted methods of diagnosis and treatment." *Id.* at 4. But, instead of using "accepted methods of diagnosis and treatment," DHHS and its agents have instructed service coordinators, who have no medical training, to determine medical necessity and to override physicians' orders instead of applying those standards mandated in the South Carolina Medical Practice Act. *Moore v. Cook, supra*. South Carolina law specifically defines the practice of medicine, stating in Section 40-47-40 of the 1976 Code of Laws of South Carolina, as amended, as follows:

Any person shall be regarded as practicing medicine within the meaning of this article who (a) shall as a business treat, operate on or prescribe for any physical ailment of another (b) shall engage in any branch or specialty of the healing art or (c) shall diagnose,

cure, relieve in any degree or profess, or attempt to diagnose, cure or relieve any human disease, ailment, defect, abnormality or complaint, whether of physical or mental origin, by attendance or advice, by prescribing, using or *furnishing any drug, appliance, manipulation, adjustment or method or by any therapeutic agent whatsoever.* (Emphasis added.)

Clearly, determining the medical necessity and prescribing durable medical equipment is the practice of medicine in South Carolina, and reasonable standards would require that the persons responsible for making these decisions must be licensed physicians. Section 40-47-60 of the South Carolina Code of Laws states that:

No person shall practice medicine, surgery or osteopathy within the state unless he is twenty-one years of age and has been authorized to do so pursuant to the provisions of this article.

South Carolina Medical Practice Act requires that medical treatment decisions must be made by physicians. It does not allow DDSN service coordinators, who have no medical training, or DDSN bureaucrats to make medical treatment decisions. In accordance with the South Carolina Administrative Procedures Act (S.C. Code Ann. Section 1-23-40), the South Carolina Board of Medical Examiners published a notice interpreting the South Carolina Medical Practice Act and the Principles of Medical Ethics, as adopted by the Board at the February 5-7, 2001 meeting found at: <http://www.llr.state.sc.us/pol/medical/index.asp?file=Policies/MedNecessity.htm>. This notice states that:

It is the position of the State Board of Medical Examiners for South Carolina that the act of determining medical necessity or appropriateness of proposed medical care, so as to affect the diagnosis or treatment of a patient located in South Carolina, is the practice of medicine, as defined by Section 40-47-40 of the 1976 Code of Laws of South Carolina, as amended, and must be made by a physician licensed to practice medicine in this State. Making determinations of medical necessity or appropriateness of medical care requires independent medical judgment that is reserved to physicians, especially determinations to deny, reduce, or terminate health care services or to deny payment for a health care service because that service is not medically necessary. To engage in such determinations

so as to affect the diagnosis or treatment of a patient in South Carolina requires a South Carolina medical license.

The requirement of having a physician to make treatment decisions is also supported by regulations which require private insurers in South Carolina must comply with which contain strict criteria for determining medical necessity. South Carolina Administrative Code § 69-47. *Private Review Agents*. Utilization criteria for denial of medical services “must be established under the direct supervision of a health care provider licensed in the same profession and practicing in the same or a similar specialty as typically manages the medical condition, procedure or treatment.” The “reasonable standards” requirement in the Medicaid Act would require the agencies to comply with this statute.

Reasonable standards require Defendants to comply with both state and federal law, including the South Carolina Administrative Procedures Act, which prohibits agencies from establishing binding norms without promulgating regulations. Instead of promulgating regulations which comply with these laws, regulations and policies, Defendants have arrogantly informed the federal court that DDSN and DHHS have no intention of complying with the South Carolina Administrative Procedures Act by promulgating regulations for the operation of Medicaid programs. Exhibit 28 at page 55. The South Carolina Administrative Law Court has repeatedly held that decisions placing arbitrary limits on services are not enforceable, because they have not been promulgated as regulations. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0656-AP (S.C.A.L.C. July 19, 2011). *Edge, Eubanks, Morgan and Myers v. DHHS*, Docket No. 10-ALJ-08-0504 (S.C.A.L.C. 2011).¹⁰

In South Carolina, as in most states, a binding agency policy that has not formally been promulgated as a regulation in accordance with the Administrative Procedures Act (APA) cannot

¹⁰ *Stogsdill v. DHHS*, Case No. 2013-00762, is pending in the South Carolina Court of Appeals. Appellate Case No. 2013-000762.

carry the force and effect of law. S.C. Code Ann. 1-23-10(4) specifically states that “policy or guidance issued by an agency other than a regulation does not have the force or effect of law.” Respondent and its hearing officers have treated the across the board caps as a binding rule, but the failure to properly promulgate these changes as regulations, in accordance with the APA renders them invalid and unenforceable. *Hickey v. DHHS, supra*. Although an agency is free to develop applicable policies and procedures without the promulgation of regulations, once these policies and procedures reach the level of being applied as “binding norms” by the agency, they must go through the APA process to be enforceable. *Home Health Serv., Inc. v. S.C. Tax Com’n*, 312 S.C. 328, 440; 440 S.E.2d 375, 378 (1994). To determine whether a challenged policy leaves the agency free to exercise discretion to follow or not follow the policy at issue in a particular situation depends upon whether the agency treats it as a binding norm. *Sloan v. S.C. Bd. Of Physical Therapy Exam’rs*, 370 S.C. 452, 476; 636 S.E.2d 598, 610 (2006). When the policy at issue “so fills out the statutory scheme” that the agency will only look to whether the policy’s criteria are met in taking action or rendering a decision, the policy is considered by the court to be a “binding norm.” *Id.* If, however, the agency remains “free to follow or not follow the policy in an individual case, the agency has not established a binding norm and no promulgation of the policy is necessary. *Id.* See also *Ryder Truck Lines, Inc. v. U.S.*, 716 F.2d 1369; 1377 (115h Cir. 1983). Further, the Supreme Court has cautioned that in cases where it is a “close question whether a pronouncement is a policy statement or a regulation, the [agency] should promulgate the ruling as a regulation in compliance with the ADA.” *Sloan* at 475.

In this case, the Defendants has, throughout these proceedings, treated the 2010 caps and other reductions of services as a binding norm by which all recipients are bound, without exception to their individualized needs. Because the benefit cuts have been treated and applied as a binding norm, DHHS was required to promulgate them as a regulation under the plain terms of the APA. This Court should note that the Respondents’ failure to do so is not a new phenomenon and it should not be countenanced by this Court. For example, in *Corbett v. DHHS*, the

Respondent argued (unsuccessfully) that DHHS was not required to promulgate regulations concerning the waiver program, despite the fact that the agency treats the Manual as a binding document. No. 07-ALJ-08-0278-AP (July 16, 2008). In a firm rejection of this argument, the Administrative Law Court held that “CMS’ approval of the State’s Medicaid Plan or Manual does not make it a binding document...[and] it must be promulgated as a regulation” in order to be considered “binding.” *Id.*

The APA requires a state agency to comply with specific, statutorily mandated steps before a policy can become a regulation. S.C.Code of Laws 1-23-110 to 160, *Sloan*, 370 S.C. 452, 474 (2006). Binding norms that are not “established pursuant to rulemaking formalities” under the APA are “unenforceable, null and void, and without legal effect.” *W. Carolina Reg’l Sewer Auth. v. SCDHED*, Nos. 98-ALJ-07-0267-CC; 98 ALJ-07-0585-CC (Sept. 22, 1999), 1999 ENV. LEXIS 102.

Plaintiffs request that this Court grant their motion for summary judgment on these issues, finding that the Defendants have violated the reasonable standards requirement of the Medicaid Act and the requirement to promulgate regulations under the South Carolina Administrative Procedures Act. Plaintiffs request that the Court issue a permanent injunction against Defendants prohibiting the enforcement of caps against persons who would otherwise require care in a more restrictive setting. Plaintiffs request an order prohibiting DHHS from denying medical services ordered by Plaintiff’s treating physicians based on binding norms that have not been promulgated as regulations and such other relief, including legal fees and costs, as the Court shall determine to be just and fair.

ISSUE #3 Defendants have violated the Americans with Disabilities Act in the administration of DDSN Medicaid waiver programs.

In *Olmstead v. L.C.*, the Supreme Court recognized the importance of the benefits of community integration for individuals with disabilities. In its analysis, the plurality pointed to the historic significance of the ADA: Congress enacted the ADA in order to “provide a clear and

comprehensive national mandate for the elimination of discrimination against individuals with disabilities.” 42 U.S.C. § 12101(b)(1) cited in *Olmstead* at 589. The Court went on to examine the reasoning driving the enactment of the ADA and noted that in passing the statute, Congress recognized that “historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a pervasive social problem.” 42 U.S.C. § 12101(a)(2) cited in *Olmstead* at 588-589. The integration of individuals with disabilities into the mainstream of society is thus fundamental to the purposes of the ADA.

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

Nine years after Congress enacted the ADA, in *Olmstead*, the United States Supreme Court relied upon the interpretation of that statute by the Attorney General, declaring that the integration mandate of the ADA forbids “unnecessary segregation” and “unjustified isolation” of persons with disabilities and that such segregation and that isolation is a form of prohibited discrimination. 527 U.S. 581, 582, 600-601 (1999). In that case, the Supreme Court clearly defined the “most integrated setting” as the “setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.” 527 U.S. at 592. When Defendants administer services in a way that puts individuals who have disabilities at risk of

involuntary institutionalization, as the Defendants have done in this case, they violate Title II of the ADA and the mandates of the Supreme Court in *Olmstead*.

It is uncontradicted that Rob and Richard are disabled persons, as defined by the ADA. They do not object to receiving services in the community, indeed, that is exactly what they have requested. Defendants have repeatedly determined that they may be served in the community.

The Supreme Court held that the State is not required to provide services that would cause a fundamental alteration in its programs. But Plaintiffs have demonstrated that the cost of the ID/RD Medicaid program increased by more than \$50 million when DHHS implemented the 2010 caps on services. Exhibits 8 and 9. See article from Wall Street Journal reporting South Carolina's imposition of caps on waiver services at Exhibit 6. The average cost per participant in the ID/RD program increased by thousands of dollars per person. During FY 2010, according to the State Comptroller, DHHS failed to spend nearly one quarter of its budget, allowing more than \$210 million to "lapse." Deposition of Peter Legitt at pages 56 to 58, lines 1 to 4. Exhibit 30. Director Keck also could not explain in his deposition how DHHS allowed hundreds of millions of dollars to "lapse." Page 33, line 3. This would have resulted in a loss of more than \$800 million, because the federal match for these funds was lost. According to the former DDSN internal auditor, the cost of continuing the waiver services that were cut would have been about \$4.6 million a year, with 70% of these funds provided by the federal government. Exhibit 7. Prior to 2010, there were no caps on services in DDSN waiver documents. Exhibit 22. Approved hours were appropriated on an hourly basis, so that waiver participants were not required to "use them or lose them." Exhibit 26. This allowed waiver participants to "bank" hours to provide additional care in the event of a family emergency. *Id.*

Defendants had the option of limiting new persons being served by the waivers, if they did not have sufficient funding to provide services. Exhibit 2. But *Olmstead* Directive Number 4 clearly instructed South Carolina, that they cannot limit access to services based on budget

reductions. Instead, DHHS increased the number of waiver participants in the program dramatically, while cutting services for the most disabled waiver participants. This year, DDSN is receiving more than \$50 million in new money to add even more participants to the waiver program. But no efforts have been made to use some of that money to restore services to persons who will eventually cost taxpayers more when they are institutionalized due to lack of supports in the home. (Information on this increase in funds is in the South Carolina Budget Act and will be provided to the Court.)

Defendants have failed in any way, shape or form to meet their burden of proving that providing the services Plaintiffs request, so that services will be provided according to the needs identified by treating physicians, would cause a fundamental alteration in South Carolina's programs. Plaintiffs request that this Court issue a declaratory order finding that Defendants have violated the Americans with Disabilities Act in the operation of their programs and enjoining DHHS from continuing to violate the Act. They request that this Court declare the caps on services to be violative of the Americans with Disabilities Act. DHHS should be ordered to provide covered services, without regard to the illegal caps, as ordered by Plaintiffs' treating physicians, unless a qualified physician determines, after examining the waiver participant, that those services are not medically necessary. Plaintiff also respectfully requests payment of legal fees and costs associated with this action.

ISSUE #4 Defendants have violated the Medicaid Act and Plaintiffs' Civil Rights

In the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. 1396-1396w-5, Congress established a medical assistance program which is cooperatively funded by the federal and state governments. In South Carolina, the federal government pays approximately 70% of the cost of the program, with South Carolina paying only 30% of the cost of services provided.¹¹

¹¹ For several years, beginning in 2010, the federal government contributed nearly 80% of the cost of the program in South Carolina. When DHHS imposed caps on Medicaid waiver services in 2010, South Carolina was receiving an 80/20 match from the federal

Medicaid is designed to enable each state “to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence and self-care...” 42 U.S.C. 1396-1. States are required to administer Medicaid programs “in the best interest of recipients.” *Id.* 1396a(a)(19).

The Centers for Medicare & Medicaid Services (CMS) is the federal agency empowered by Congress to administer the Medicaid program at the federal level. CMS rules and regulations for the administration of the Medicaid program are set forth in 42 C.F.R. 430.0-483.480, and in the CMS *State Medicaid Manual*, hereinafter referred to as the “SMM.” CMS State Medicaid Manual is available at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>. These rules and regulations are binding on all states that participate in the Medicaid program. *Doe v. Kidd I, supra.*

The Medicaid Act requires each state to designate a State Medicaid Agency which is responsible for operating a vender payment program, where qualified providers are reimbursed for the services they provide. The State Medicaid Agency does not directly provide health care services to eligible individuals or pay money to beneficiaries to purchase health care directly. The South Carolina General Assembly authorized DHHS to administer the Medicaid Program, directing DHHS to prepare state plans and to allocate resources in compliance with state and federal laws.¹² S.C. Code of Laws 44-6-30 and 44-6-70. The General Assembly has directed DHHS to give specific attention to (1) prevention measures in health and human services

government.

¹² DHHS has contracted with the South Carolina Department of Disabilities and Special Needs to administer the Medicaid programs at issue in this case. S.C. Code Ann. § 44-6-30(1); *Doe v. Kidd I*, 501 F.3d 348, 351 (4th Cir. 2007), *cert. denied*, 128 S. Ct. 1483 (2008).

programs, (2) regulations, coverage and reimbursement policies tailored to the client's needs and delivered in the most cost-effective manner and (3) optimum cost effectiveness in the delivery of services provided quality of care is assured. Anthony Keck, as the Director of DHHS, is responsible for the preparation of federal funding plans, compiling information on Medicaid programs and continually reviewing and evaluating Medicaid programs.¹³ S.C. Code § 44-6-40 and 44-6-100. He is responsible for developing fiscal information on Medicaid programs, assuring that Medicaid programs are administered effectively, equitably and economically and keeping the Governor and the General Assembly informed as to the effectiveness of Medicaid programs. Id. DDSN Regulation § 126-399 provides that "When the requirements of the State and the Federal regulations are not in agreement, the requirements of the Federal regulations shall prevail."

The Medicaid Act requires the state to adopt a written State Plan meeting all of the requirements of the Act, which must be submitted to CMS. 42 U.S.C. 1396; 42 C.F.R. 430.12. Some Medicaid programs are mandatory once the state elects to receive matching federal Medicaid funds. "State Plan" services include physician services, hospitalization, medications and other certain medically necessary services, but these services do not include attendant care, nursing, companion services, durable medical equipment and some of the therapies and long term care services covered by Medicaid waiver programs prior to 2010. Millender et. al, *A Practical*

¹³ In *D.T.M. v. Cansler*, the Fourth Circuit held that the official "responsible for assuring that the agency's decisions comply with federal law, was properly named as the defendant." Case No. 09-1441 (4th Cir. June 11, 2010), citing *See Ogden v. United States*, 758 F.2d 1168, 1177 (7th Cir. 1985). ("[W]here injunctive, as opposed to monetary relief is sought, no direct and personal involvement is required in order to hold high-level officials responsible for the actions of subordinates and to subject them to the equitable jurisdiction of the court."). And, the *Ex parte Young* exception was therefore properly applied to him. *See Antrican*, 290 F.3d at 188-89 (holding *Ex parte Young* exception was properly applied to state officials overseeing the North Carolina Medicaid program in suit alleging wrongful denial of Medicaid services).

Guide to Elder and Special Needs Law in South Carolina, S.C. Bar 2014. In addition to “State Plan” services, states that participate in Medicaid must also provide nursing facility services for individuals over age 21 years of age. 42 U.S.C. 1396d(a)(4)(A).

Federal funding for other Medicaid services and programs is available to states that elect to provide additional optional programs. These optional programs include the home and community based waiver programs authorized by Section 1915 of the Social Security Act, sometimes referred to as “1915 waivers.” The purpose of home and community based waiver programs is to provide severely disabled persons, who meet level of care criteria for Medicaid funded institutional care, the alternative of receiving services that will allow them to live in the least restrictive setting. *Doe v. Kidd II*, Case No. 10-1191 (4th Cir. March 24, 2011).

Section 1915 “waives” the requirement that the participants be placed in an institution to receive services previously only provided through Medicaid funded institutional programs. Other than the waiver of institutional placement, only three other requirements of the Medicaid Act can be waived, and then only with the specific permission of CMS:

1. The "statewide" rule, which requires a state plan to "provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them." 42 U.S.C. § 1396a(a)(1).
2. The "comparability" rule, which prohibits a state plan from providing certain specified recipients of medical services with services that are "less in amount, duration, or scope than the medical assistance made available to" other recipients of services under the plan. 42 U.S.C. § 1396a(a)(10)(B).
3. Various income and resource rules, which restrict services to the very neediest members of the community. *See* 42 U.S.C. § 1396a(a)(10)(C)(i)(III).

(“Thus, the Medicaid Act's authorization of HCBS waivers permits the Secretary, by granting such a waiver, to relieve a state from compliance with three — and only three — of the otherwise-mandatory requirements on which the Medicaid Act conditions receipt of federal funds.” *Arc of California v. Douglas*, 13-16544 (9th June 30, 2014). *However, South Carolina has neither requested, nor received permission to waive any of these three requirements.*

As the Ninth Circuit noted in *Arc*, “The list of waivable requirements in 42 U.S.C. § 1396n(c)(3) is exclusive. Nothing in the HCBS waiver provision provides the Secretary with authority to

waive any *other* of the Medicaid Act's requirements when granting an HCBS waiver." The Fourth Circuit has so instructed the South Carolina Department of Health and Human Services that they are bound by the requirements of the Medicaid Act as a condition of accepting federal funds. *Doe v. Kidd I and II, supra*.

Under a home and community based waiver program, states "may provide services that are not otherwise available under the Medicaid statute." Exhibit 2. DHHS Olmstead Update No. 4. *See*

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd011001a.pdf>

Section 1915 allows States to develop Medicaid waiver programs which target specific groups. In this case, Plaintiffs Rob and Richard receive both "State Plan" services and Medicaid waiver services. Rob participates in a plan designed to allow persons who have head and spinal cord injuries to live in their homes and communities (HASCI waiver). Richard receives services under the ID/RD Medicaid waiver program for persons who have intellectual disabilities or related disabilities. These programs require the State to give the participant the choice of receiving institutional Medicaid funded services in an ICF/MR or a nursing home or receiving Medicaid waiver services in a less restrictive environment.

Section 1396a(a)(17) of the Medicaid Act provides that "[a] State plan for medical assistance must ... include reasonable standards ... for determining eligibility for and the extent of medical assistance under the plan which ... are consistent with the objectives of this [Title]." *Moore v. Reese*, 637 F.3d 1220, 1232, *See also Moore v. Cook*, 1:07-cv-631 (N.D.Ga. April 19, 2012) and *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013). As the Court of Appeals for the Eighth Circuit noted in *Lankford v. Sherman*: "CMS (the agency that administers Medicaid) maintains that the reasonable-standards provisions apply to all forms of medical assistance..." 451 F.3d 496, 506 (8th 2006). The Medicaid Act also requires that state plans "provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity

of administration and the best interests of the recipients." *Id.* § 1396a(a)(19).

The "comparability" mandate of the Medicaid Act contained in 42 U.S.C. 1396a(a)(10) requires states to provide medical assistance to any individual in a covered medical group with services that "shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual [within the same classification]" *Schott v. Olszewski*, 401 F.3d 682,687 (6th Cir. 2005). See also *Arc v. California v. Douglas*, Case No. 13-1544 (9th Cir. 1544). See also *Pashby v. Delia*, 709 F.3d 307, 325 (4th Cir. 2013). 42 C.F.R. § 440.240(b) provides that "The plan must provide that the services available to any individual in [a covered medically needy group] are equal in amount, duration, and scope for all recipients within the group." *Bontrager v. Indiana Family and Social Services Admin.*, 697 F.3d 604, 608 (7th Cir. 2012).

The "equal access" mandate of the Medicaid Act found at 42 U.S.C. § 1396a(a)(30)(A) requires States to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as . . . are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." *Antrican v. Odom*, 290 F.3d 178, 187 (4th Cir. 2002). A state cannot comply with Section 30(A) without "responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting, " reasoning that a state "cannot know that it is setting rates that are consistent with efficiency, economy, quality of care and access without considering the costs of providing such services." *Arc of California, supra*. Furthermore, the Medicaid Act prohibits "balance billing," or requiring any person, including the parent of an adult Medicaid participant from paying any portion of the cost of Medicaid services. Requiring parents to pay for Worker's Comp and liability violates this requirement.

Plaintiffs request a ruling that DHHS has violated the comparability, reasonable promptness and equal access requirements of the Medicaid Act. Richard filed an appeal

requesting additional services in 2007, but it took six years before he even got to the gate of the Judicial Branch of State government, while his condition has continued to deteriorate. Rob was not even informed that he has a right to receive nursing services and his services were reduced based on phony claims of “budget reductions.” The rates paid to providers has hindered participants access to care, especially the rates paid to respite providers. DHHS has illegally forced parents to shoulder the financial burden of providing care, even risking their own financial security by putting them at risk of lawsuits by State entities claiming that they are the “employer of record,” so that the State agencies can defraud the Worker’s Compensation fund. Exhibit 34. See Affidavit of Richard Detweiler. Exhibit 34.

CONCLUSION

Plaintiffs pray for an order granting them summary judgment, interim legal fees and costs based on this motion and memorandum, in addition to pleadings, declarations and documents previously filed by the Plaintiffs.

Respectfully submitted,

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July 30, 2014

- Exhibit 1 Request for Proposal for DDSN Services August 3, 2011
- Exhibit 2 Olmstead Update No. 4
- Exhibit 3 *Ex parte* Memo February 18, 2010
- Exhibit 4 Email from DOJ attorney August 24, 2011
- Exhibit 5 SC Commission on Disabilities and Special Needs Work Session September 16, 2010
- Exhibit 6 *Wall Street Journal* article re 2010 Medicaid reductions
- Exhibit 7 Affidavit of Steven Jeffcoat, former DDSN internal auditor
- Exhibit 8 CMS Letter to SCDHHS November 2008
- Exhibit 9 CMS Letter to SCDHHS November 2009
- Exhibit 10 SC Legislative Audit Council 2008 Review of DDSN
- Exhibit 11 Mullis v. SCDDSN & SCHHS (Mullis I), 2004
- Exhibit 12 Mullis v. SCHHS (Mullis II), 2010
- Exhibit 13 Emails from/to Service Coordinator re ICFMR for Richard S.
- Exhibit 14 Richard S. *Amici* Brief in SCCA February 21, 2014
- Exhibit 15 Deposition of Peter Liggett
- Exhibit 16 Deposition of Elizabeth Hutto, Part I, Pp 1-70
- Exhibit 17 Deposition of Elizabeth Hutto, Part II, Pp 71-125 & Index
- Exhibit 18 Deposition of Anthony Keck, Part I, Pp 1-86
- Exhibit 19 Deposition of Anthony Keck, Part II, Pp 87-172
- Exhibit 20 2012 Support Plan for Richard Stogsdill
- Exhibit 21 Waddle Petition/Complaint for Remedial Writ, SCALC, June 23, 2014
- Exhibit 22 Waddle SCDHHS Administrative Decision November 19, 2013

Sheet 2

- Exhibit 23 Waddle Hutto's Order December 23, 2013
- Exhibit 24 Declaration of Nancy Stogsdill July 30, 2014
- Exhibit 25 Declaration of Lennie Mullis July 30, 2014
- Exhibit 26 Affidavit of Lennie Mullis 2009
- Exhibit 27 Affidavit of Thomas C. Joseph, MD 2010
- Exhibit 28 Deposition of Kara Lewis
- Exhibit 29 Declaration of Mary Self July 30, 2014
- Exhibit 30 2010 Report of SC Comptroller General
- Exhibit 31 Eligibility Diagnostic Criteria, Revision July 1, 2014
- Exhibit 32 Waddle v. SCDHHS: Motion by SCDHHS to Dismiss Petition/Complaint for Remedial Writ
- Exhibit 33 Declaration of Carolyn B. Brown September 4, 2013
- Exhibit 34 Expert Report of Richard Detweiler, Esq.