

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

Case No. 2013-002415

Brook Waddle Appellant,

v.

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

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SC Court of Appeals

APPELLANT'S RESPONSE TO MOTION TO DISMISS

Appellant prays that this Court will deny Respondent's motion to dismiss her appeal.

This appeal was initiated in this Court by filing a notice of appeal on or about November 12, 2013. Appellant has filed an initial brief and has twice consented to extensions of time for Respondent to file its brief, which was due on November 24, 2014. However, instead of filing a brief, Respondent filed a motion to dismiss Appellant's appeal. Rule 240 allows a party to file a motion, but Rule 240(b) clearly states that filing a motion does not stay time limits. Appellant prays that this Court will either order Respondent to file its brief or will grant the relief requested by Appellant.

Respondent has attempted to dismiss Appellant's appeal based on an affidavit of a DHHS

employee not contained in the Record. Of course, Appellant had no opportunity to cross examine this employee or to build a record required by 42 C.F.R. 431.244. This is a classic example of the government attempting to moot an appeal by voluntary mootness, consciously disregarding the consequences to this Medicaid participant who suffers from quadriplegia. As the Fourth Circuit recognized in *Doe v. Kidd I*: A case is moot "'when the issues presented are no longer 'live' or the parties lack a legally cognizable interest in the outcome." 501 F.3d 348, 354. Citing *Powell v. McCormack*, 395 U.S. 486, 496, 89 S.Ct. 1944, 23 L.Ed.2d 491 (1969). Brook's case is not moot, because she will continue to depend upon services provided by DHHS to remain alive and the violations she has complained of will be repeated, thereby denying her due process. In *Doe*, the Fourth Circuit refused to dismiss Doe's case, recognizing that it is "well settled that [the] defendant's voluntary cessation of a challenged practice does not deprive a federal court of its power to determine the legality of the practice unless it is absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur." *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 189, 120 S.Ct. 693, 145 L.Ed.2d 610 (2000) (quotation marks and citations omitted). Appellant respectfully argues that Respondent's motion should not be granted, because Appellant has challenged not simply the failure to provide one inexpensive piece of equipment, but she has challenged DHHS' ongoing refusal to comply with fundamental due process and the explicit requirements of the Medicaid Act, federal regulations interpreting that Act and the State Medicaid Manual, the policy manual issued by CMS, the federal agency authorized by Congress to administer the Medicaid Program.

The fair hearing regulations are discussed by the DHHS hearing officer at page 25 of the in the attached November 19, 2013 order issued in Brook's 2007 appeal. Exhibit 1. 42 U.S.C.

1396a(a)(3) requires DHHS to provide a fair hearing. Federal regulations require that the State must comply with the due process requirements established by the United States Supreme Court in *Goldberg v. Kelly*, as well as the regulations contained in 42 C.F.R. 431.202 et. seq. 397 U.S. 254 (1970). At pages 7 and 8 of the November 19, 2014 order, the hearing officer discusses DHHS' failure to provide Brook with notice meeting the requirements of 42 C.F.R. 431.210. On page 20, the hearing officer discusses four separate occasions where Brook's services were reduced without providing the mandatory notices (paragraphs 4, 5, 6 and 7). DHHS requested reconsideration of this Order, issued by its own hearing officer. Exhibit 2. DHHS has refused to comply with DHHS' own Order, without regard for the continuing deterioration in Brook's condition and the hardships to this family. Exhibit 3 and 4. Instead of providing the services ordered by its hearing officer, DHHS filed a motion to dismiss Brook's Petition/Complaint with the Administrative Law Court. DHHS' own order, and its stubborn refusal to comply with it, demonstrates that the violations complained of in this appeal are reasonably likely to recur.

Federal regulations require that Medicaid services be provided with "reasonable promptness." 42 U.S.C. 1396a(a)(8). In *Doe v. Kidd I*, the Fourth Circuit noted that courts have interpreted "reasonable promptness" to mean within 45 or 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).

501 F.3d 348, (4th Cir. 2007). In *Doe v. Kidd II*, the Fourth Circuit found that DHHS had abdicated its responsibility to provide residential habilitation services with reasonable

promptness. Case No. 10-1191 (4th Cir. March 24, 2011).

42 U.S.C. 1396a(a)(3) requires DHHS to provide a fair hearing. Federal regulations require that the State must comply with the due process requirements established by the United States Supreme Court in *Goldberg v. Kelly*, as well as the regulations contained in 42 C.F.R. 431.202 et. seq. 397 U.S. 254 (1970). Appellant has appealed to this Court the ongoing failure of DHHS to provide notices of denial of service meeting the clear and unambiguous requirements of 42 C.F.R. 431.210. Respondent does not, and can not honestly claim that this violation did not occur.

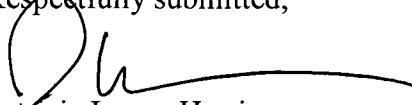
Appellant has also complained of the ongoing violations of 42 C.F.R. 431.244(a), which require DHHS hearing officers to base their decisions “exclusively” on evidence presented at a hearing. Obviously, if no hearing is provided, the hearing officer’s order dismissing a “fair hearing” appeal cannot be based exclusively on evidence presented at the hearing. Like the failure to provide notices meeting the requirements of the Medicaid regulations, this violation is ongoing and is likely to recur. CMS regulations are very specific about when a “fair hearing” appeal can be dismissed. The applicable regulation is contained at 42 C.F.R. 431.223. Pursuant to this regulation, DHHS may only dismiss a fair hearing appeal if the Medicaid participant requests dismissal in writing, or if the participant fails to appear at a hearing. Yet, DHHS continues to burden poor and disabled Medicaid participants with just the same illegal obstacles that the United States Supreme Court held to be unconstitutional in *Goldberg*.

Review by this Court is critically important, because the federal district court recently ruled that a Medicaid participant who has an appeal pending in the state court cannot maintain an action in the federal court for violation of the Medicaid Act and the Americans with Disabilities

Act. *Stogsdill v. Sebelius*, Case No. 3:12-cv-00007 (D.S.C. November 10, 2014). DHHS has consistently contended in the federal courts that the “fair hearing” administrative appeal process is the only remedy available to Medicaid participants for violation of the Medicaid Act and the ADA. *Doe v. Kidd I and II*, supra, *Peter B. v. Sanford*, Case No. 6:10-cv-00767-JMC -BHH (D.S.C. November 24, 2010).

Appellant prays that this Court will deny Respondent’s motion to dismiss, because her claims for violation of her due process rights and rights under the Medicaid Act, and other rights contained in her appeal remain live and it is likely that the agency will again reduce or deny services and will fail to provide services with reasonable promptness. Once again, instead of simply following the law and providing Appellant with the right to administrative, then judicial review, Respondent continues to waste judicial resources and taxpayer dollars by attempting to obstruct Appellant’s due process rights. Appellant prays for an order finding that the agency acted without substantial justification and an award of interim legal fees and such other relief as this Court may determine to be right and just.

Respectfully submitted,



Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
803 256 2017
plh.cola@att.net

Kenneth Anthony
PO Box 3565
Spartanburg, South Carolina 29304
803 582 2355
Attorneys for Appellant

December 4, 2014

LIST OF EXHIBITS

- Exhibit 1 B.W. v. DHHS, November 19, 2013 Order
- Exhibit 2 B.W. v. DHHS, December 23, 2014
- Exhibit 3 B.W. v. DHHS, Response to DHHS' Motion filed May 1, 2014
- Exhibit 4 B.W. v. DHHS, Petition/Complaint for Remedial Writ filed June 23, 2014
- Exhibit 5 B.W. v. DHHS, Motion to Dismiss Petition/Complaint for Remedial Writ filed July 23, 2014

Exhibit 1 B.W. v. DHHS, November 19, 2013 Order

Nikki Haley GOVERNOR
Anthony Keck DIRECTOR
P.O. Box 8206 · Columbia, SC 29202
www.scdhhs.gov

November 19, 2013

CERTIFIED MAIL

Patricia Harrison, Esquire
611 Holly Street
Columbia SC 29205

RE: Administrative Decision in the Appeal Matter of Brook Waddle v. SCDHHS
Appeals' Case # 07-MISC-028
Medicaid # 6780499394

Dear Ms. Harrison:

Enclosed please find the Administrative Decision in the above-referenced matter.

Any party has the right to petition for further review of this Decision, as provided in the Administrative Procedures Act. S.C. Code Ann. Section 1-23-310, et seq., (1976, as amended). To request an appeal, a Notice of Appeal must be filed with the Administrative Law Court, 1205 Pendleton Street, Brown Building – Suite 224, Columbia, S. C. 29201-3755 within 30 days of the receipt of this Decision. A copy of the Notice of Appeal should be provided to counsel for the opposing party. The Notice of Appeal must be submitted in accordance the Rules of Procedure for the S.C. Administrative Law Court. This matter was previously transcribed to assist me in producing this Decision. I believe the attorneys for both parties have a copy of this transcript. Should either party pursue an appeal, I will certify the transcript and produce it to the Administrative Law Court.

Sincerely,



Elizabeth B. Hutto
Program Director, Division of Appeals and Third Party Liability
Interim CFO, SCDHHS

EBH/ss
Enclosures (2)

Patricia Harrison Esquire

November 19, 2013

Page Two

cc: George Maky, Department Head, Community Waivers, SCDHHS
Office of General Counsel, SCDHHS
Richard Hepfer, Esquire, Deputy General Counsel, SCDHHS
Tana Vanderbilt, Office of General Counsel, SCDDSN
Linda Veldheer, Director, HASCI Waiver, SCDDSN
Brook Waddle
Sandra Waddle

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

RN to come out for two hours per day, participants who have RN hours usually have the RN come out for at least half a day.

Dr. Veldheer discussed the difficulties families face in finding RN care. It appears as though the Respondent requires the families and the participants to secure the type of care and hours needed rather than requiring the Service Coordinator to provide that assistance. Dr. Veldheer noted that, frequently, the family or the participant must seek out a number of nursing agencies to find one that will meet their needs. Dr. Veldheer testified that, as the nursing agencies are private companies, they can choose to accept a case or not and, as private companies, they may or may not have the appropriate staff for every case. T. at 221. "...for these families, it's a constant process to get the kind of staffing you need in your authorized hours." T. at 237. Dr. Veldheer did not know how "diligent" the Petitioner's family had been in seeking RN care for her. T. at 237.

In spite of the history of this appeal with RN hours as a central issue, Dr. Veldheer believes that the Petitioner has not requested RN services. T. at 237. However, Dr. Veldheer feels that an RN should see the Petitioner "at least every week, either for a few hours or for a day." T. at 220-221. Apparently, due to her misunderstanding of the Petitioner's request for care, Dr. Veldheer had not previously suggested that the Petitioner receive RN services even though she was aware that the Petitioner needed such care.

In accordance with the Service Plan, the RN hours were to be evaluated after 30 days, but continue in some amount per week. The record shows no evidence of an evaluation of the Petitioner after her first 30 days home from the hospital. Dr. Veldheer did not know whether there was an evaluation by a doctor after the first 30 days nor did she know whether the

Petitioner has ever had an evaluation by a doctor that finds that Petitioner does not need 14 hours per week of RN care. T. at 67.

The Petitioner has never received ongoing RN care at home. The service provider sends an RN to the home periodically to supervise the LPN by checking her paperwork. T. at 205. The RN's review of the LPN's care is not part of the Petitioner's service plan or a requirement of the Respondent. Dr. Veldheer is aware of this supervisory arrangement but seems to feel the management of the quality of care provided to the Petitioner is the responsibility of the contracted service provider. Dr. Veldheer testified that she does not know how often the supervising RN comes to Petitioner's home and that SCDDSN does not have standards for that supervision. T. at 233. "We don't have standards because we don't provide nursing services. The provider is the nursing agency and they have standards" T. at 234

Since Jan 2010, the Waiver stated that the combination of nursing and attendant cannot exceed 70 hours per week. The hours can be used flexibly throughout the week. Prior to that time, there was a 12 hour per day limit. T. at 218. The mix of attendant and nursing care is according to what the recipient requests and what gets approved by the centralized nursing review. Dr. Veldheer pointed out that, under current limits, the Petitioner could receive 56 hours per week of LPN. That would give the Petitioner's mother 8 hours per day to leave the home, sleep, etc. T. at 220-221. However, Dr. Veldheer does not know whether the Petitioner is aware of that option. Dr. Veldheer knows that the Petitioner has been told that the maximum LPN nursing hours she could get was 34. Dr. Veldheer explained that B.W. was told that 34 LPN hours were the maximum she could receive because she was receiving 36 hours of attendant care at the time. T. at 230. Dr. Veldheer did not seem to feel that she should have clarified for the

Petitioner that there was not a 34 hour LPN limit but that nursing hours and attendant hours could be combined in a suitable way for the Waiver participant within the limits.

The Service Coordinator has the authority to determine the hours of attendant care. T at 78. Petitioner's Service Coordinator felt her opinion as to whether the Petitioner required 24 hours per day of care was "not relevant." Also, the Service Coordinator believes her opinion as to whether the Petitioner can be left alone is "not relevant." T. at 89.

During the 2009 hearing, the Petitioner's treating physician, Dr. Gabel, testified via affidavit stating that she agreed with Dr. Silvestri's assessment that the Petitioner required 28 hours per week of RN services "to provide observation, intervention and to prevent regression and identify medical problems which, if left untreated, would require readmission to the hospital." Dr. Gabel opined that the Petitioner requires 84 hours per week of LPN services to maintain maximum functional status and to prevent institutionalization. She also stated that the Petitioner requires attendant care at all times when an RN or LPN are not present, to assure her safety. Record of 2009 Matter at 905-906. Dr. Gabel's testimony was not subject to cross examination.

The Petitioner's LPN, Ms. Galus, was one of only two witnesses at the 2012 hearing who had ever met the Petitioner and was the only witness with medical training at either the 2012 or the 2009 hearings with direct knowledge of the Petitioner's medical needs. Ms. Galus testified to the complicated and fragile medical state of the Petitioner. She also testified to the types of care that the Petitioner requires. The Petitioner needs to be suctioned throughout the day. A mucus plug in her tracheostomy tube could be deadly without a nurse or the Petitioner's mother there to suction. T. at 174. The Petitioner's trach must be cleaned frequently. Only a nurse or

the Petitioner's mother can clean the trach. T. at 179. The nurse also provides the Petitioner's bowel program and bathes her. T. at 191.

The Petitioner cannot be left alone. The Petitioner's mother must be present while an attendant or respite care provider is in the home as these service providers cannot suction the Petitioner. Therefore, the Petitioner's mother can only leave the home when a nurse is present. T. at 175. The Petitioner also requires a catheter. Only a nurse or the Petitioner's mother can reinsert the catheter if it comes out. T. at 174. Only the nurse or the Petitioner's mother can keep her safe when she suffers from a grand mal seizure. The attendant is not trained to handle seizures. T. at 198. The attendant can only sit with the Petitioner and feed her. The attendant is not qualified to provide any other care. T. at 200.

Ms. Galus described the Petitioner's frequent bouts with pneumonia which require suctioning as much as 3-5 times per hour. The Petitioner has also suffered from frequent urinary tract infections. The Petitioner has a history of decubitus ulcers and must be repositioned at least once or twice every two hours. The Petitioner has contractures and her arms cannot be straightened. If her arms are stretched, her skin will break. P.T. and O.T. would improve the contractures. However, the Petitioner is not currently receiving P.T. and O.T. services because her mother is too exhausted to take the Petitioner to therapy. T. at 177-180.

The Petitioner takes daily medications for seizures, depression, to assist with bowel movements, a stool softener, neuropathy pain, prevention of muscle spasms, prevention of bladder spasms, and for migraine headaches. The Petitioner has painful kidney stones. T. at 192-197. Since developing kidney stones, the Petitioner has had problems with her catheter leaking. Because the Petitioner cannot feel if she is wet, she is at risk of being wet for extended periods when her catheter leaks. This causes her skin to break down. T. at 194.

Ms. Galus testified that if the RN hours were 6-8 per day, the Petitioner would be able to find an RN in her area that would be willing to provide the care. T. at 200. Ms. Galus testified to the Petitioner's need for RN care due to the Petitioner's numerous medications (some administered by IV), frequent bouts of pneumonia, frequent urinary tract infections, decubitus ulcers and other skin breakdowns, and infection risks. Ms. Galus described the services an RN could provide that an LPN cannot. RNs can provide all treatment with IVs while LPNs have limited ability to work with IVs. RNs can perform lung assessments and determine when oxygen should be administered. RNs can also draw blood and monitor blood levels. T. at 205-208.

Dr. Veldheer and Ms. Wingo, the Petitioner's Service Coordinator, described the process whereby the Respondent determines the number of nursing hours that are needed by Waiver participants. Dr. Veldheer testified that after the 2010 cuts, HASCI Waiver began a centralized nurse review to make certain that participants who needed nursing services had the appropriate amount of nursing. Prior to that time, there was no nursing review at the agency to see if participants were getting the services they needed. T. at 226-227. Ms. Wingo also described the process for the annual review of nursing hours. The Service Coordinator has a form provided by SCDDSN that must be signed annually by a physician and sent to the SCDDSN centralized nurse who determines how many nursing hours are needed. According to Ms. Wingo, the SCDDSN centralized nurse is, "...the one who decided if these are appropriate or not." T. at 89. When asked about her opinion regarding whether the Petitioner needs additional services, Ms. Wingo responded that her opinion is "not relevant." T. at 91. The SCDDSN nurse who determines the Petitioner's needs has never met the Petitioner nor been to her home. The centralized nurse completes an annual record review to determine the number of nursing hours that participants

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.

Three medical record reviews conducted by the SCDDSN centralized nurse were entered into the record as Petitioner's Exhibit 28. The August 9, 2011 medical record review noted the numerous medical conditions and complications that afflict the Petitioner:

“Spastic quadriplegia – her Baclofen pump has since been removed, she now received Baclofen by mouth – she experienced an abdominal hematoma secondary to Baclofen pump removal – she had acute blood loss secondary to the hematoma.

Suprapubic catheter – neurogenic bladder – peri/catheter care – monitor for signs and symptoms of UTI

Bowel program – implemented by the nurse – history of constipation

History of pulmonary embolus in 2007 – required daily anticoagulant medications – an AV fistula was placed during a recent hospitalization in 2011 for INR checks which will need chronic checks for coagulation until measures are sufficient per Physician [perimeters]

History of experiencing 4 seizures since January 2011 that required hospitalizations and she was diagnosed with urinary tract infections which the doctors believe contributed to the seizure activity – seizure precautions/monitor for seizure activity

Since January 2011, she has required 3 or 4 hospitalizations due to chronic urinary tract infections

She experienced hypotension during her hospitalization in February, 2011, but her blood pressure has since returned to normal range – monitor vital signs

In April 2011, she was hospitalized for confusion and altered mental status which she was diagnosed with urinary tract infection

History of episodes of depression/anxiety

Tracheostomy in place – tracheoesophageal fistula

Dysphagia – GERD

Hypothyroidism

Staph coag negative bacteremia – treated with Rocephin”

Petitioner’s Exhibit 28 at 2.

The nurse’s 2011 medical record review does not indicate any improvement in the Petitioner’s condition. The nurse supported the Petitioner continuing with the ordered 22 nursing hours per week. *Id.*

According to the nurse’s 2012 report, the Petitioner’s medical diagnoses remain the same since the last review of August 9, 2011. Nurse Koon notes that the Petitioner continues to require assistance with her bowel program and supra pubic catheter care. She continues to experience urinary tract and kidney infections that require hospitalizations and experienced bilateral nephrolithiasis during a recent hospitalization. The Petitioner requires suctioning “several times day” and trach care “frequently.” The SCDDSN nurse also reported that the Petitioner requires “continued monitoring” of her skin integrity and turning to prevent decubitus ulcers. She recognized the need for medical monitoring as well as for care for anxiety, depression and seizures. Nurse Koon summarized that the Petitioner continues to require skilled care for her “multiple medical problems.” She also supported the continuation of the current authorized nursing care at 34 hours per week. Petitioner’s Exhibit 28 at 3.

Like the 2011 medical record review, the 2012 does not note any improvement in the Petitioner’s condition. In fact, the nurse has supported an increase in nursing hours by 12 hours per week. This increase in nursing hours seems to indicate that either the Petitioner’s condition

has worsened over the past year or that the previous year's 22 nursing hours per week were inadequate.

Ms. Galus testified that, on one occasion, the Petitioner's mother became ill and could not care for the Petitioner overnight. Ms. Galus stayed overnight with the Petitioner (without pay, as a favor to the family as these nursing hours offered by Ms. Galus were beyond the care that the Petitioner's Service Plan covered). Ms. Galus recounted that she was unable to sleep during the night as the Petitioner needed care every 2-3 hours including suctioning. Ms. Galus described the situation for the Petitioner and her mother as, "very, very challenging." With the exception of her mother, the Petitioner does not have good family support to help with her care. T. at 175-177. If the Petitioner's LPN is sick, there is very little substitute coverage available. Usually, there will be no substitute coverage or very little coverage on days that the LPN is out. T. at 199. Ms. Galus also testified that the Petitioner is suffering from depression and has become withdrawn. T. at 185.

Ms. Galus testified regarding the challenges surrounding Petitioner's difficulty with speaking and being understood as she cannot immediately alert her caregiver when she needs care. When she does attempt to explain her needs, it is difficult to understand as she speaks in a whisper. This communication barrier can at times delay the Petitioner getting timely care. T. at 196. The Petitioner has a whistle near her pillow which she can reach by turning her head. The whistle is used as a warning device if she is in need of care or suctioning. The Petitioner also drinks water through a straw in a cup which is also positioned within her reach by turning her head. However, if the Petitioner coughs, her arms can fly up and knock the whistle and cup out of her reach. If the Petitioner cannot reach her whistle, she could be in danger. T. at 182.

Ms. Galus testified that if the Petitioner's mother became ill, there would be no one to take care of the Petitioner. However, if the Petitioner had the hours that were ordered by her doctor (28 hours of RN and 84 hours of LPN), that would extend the Petitioner's mother's ability to care for her T. at 197-198.

The Petitioner and her mother testified via Affidavit. Although this testimony was not subject to cross examination by the Respondent; it was consistent with that of Ms. Galus in describing the Petitioner's physical condition. The Petitioner's Affidavit also provided additional details regarding her physical state including the information that she can shrug her shoulders but cannot move her body below her shoulders. The Petitioner also testified that she breathes through a trach which has to be suctioned throughout the day. She cannot breathe when she gets a mucus plug in her trach and there is no forewarning of when this will occur. Petitioner's Exhibit 12 at 3.

The Petitioner testified in the 2009 hearing that she did not want to go to a nursing home and preferred to live at home. Record of 2009 Matter at 149. Her affidavit testimony is consistent with this desire to remain in her home. She would, "rather die than go to a SCDDSN Regional Center like Whitten Center or to attend a workshop..." She also testified that she is frightened by the grand mal seizures that she has suffered. Petitioner's Exhibit 12 at 3.

I therefore find:

1. Community-based treatment is appropriate for the Petitioner and she seeks to continue community-based care.
2. The initial service plan authorized the Petitioner for 14 hours of RN services per week and required that the Petitioner's continuing need for RN services be re-evaluated after

30 days. The Petitioner's treating physician ordered 28 hours per week of RN services and 84 hours per week of LPN services.

3. The Petitioner's Service Plan also authorized 56 hours per week of LPN care and 28 hours of Attendant care.
4. The denial notices that were issued to the Petitioner prior to her initial discharge from the hospital were improper as they did not contain the statutes or regulations the actions were based upon nor did they provide instruction on how to appeal the negative action. The denial notices were sent to the Petitioner's home, although she was hospitalized at the time. Additionally, the reasons for the denials given in these notices were erroneous according to the testimony of the Respondent. The Petitioner was under 21 at the time that the denial notices were issued. The Petitioner turned 21 on January 14, 2009.
5. While pending the resolution of this appeal, the Petitioner's services were improperly reduced several times. The reductions occurred without notice and the opportunity to appeal. The reduction in 2008 occurred before the Petitioner turned 21.
6. In July 2008, the Petitioner's hours were reduced to 32 hours of LPN and 48 hours of attendant care (total of 80 hours per week). There was no notice provided to the Petitioner for this reduction.
7. In 2009, the Respondent again improperly reduced the Petitioner's service hours to 70 hours per week of combined LPN and Attendant Care. This reduction occurred during the pendency of this appeal. The Respondent again failed to provide proper notice.
8. At some point after the Petitioner was discharged from MUSC in 2007, her father moved out of the home and the Petitioner's mother became the sole family member providing

care. The Respondent should have conducted a new assessment of the Petitioner's needs when her family support was reduced to one person.

9. Upon discharge on May 9, 2007, the Petitioner was unable to find a provider of RN services willing to work the authorized hours per week and thus was unable to fill the position. The inability to locate a suitable RN was due to the Service Coordinator's erroneous assertion that the Petitioner could only receive RN hours in daily two hour increments. The Petitioner and her family relied upon this erroneous assertion. The Petitioner still has not received RN hours in her home since her initial discharge from the hospital in 2007.
10. During the pendency of this appeal, the Petitioner's mother has provided all of the care that the Respondent failed to provide due to both miscommunication and service reductions.
11. Witnesses for both parties concur that it is not possible to locate an RN who would be willing to travel to work for such a short period each day. The Petitioner and RN provider should have had the opportunity to schedule the RN hours so that the schedule best met their mutual needs.
12. The Petitioner was not re-evaluated 30 days after her initial discharge from the hospital to determine whether the 14 hours per week of RN should continue.
13. Under the current nursing hours review process, the Respondent does not seek the recommendation of the treating doctor regarding nursing hours needed by HASCI Waiver participants. The current authorization process for nursing hours requires a centralized SCDDSN nurse to perform a record review.

14. The Respondent has not provided any records which indicate that a physician for the Respondent has ever reviewed the Petitioner's medical needs.
15. The medical records review conducted by the Respondent and the testimony of witnesses for both parties indicate that the Petitioner is a quadriplegic, who relies upon a tracheostomy to breathe, and suffers from several complicated medical conditions including recurrent pneumonia, seizures, and skin break down. Due to her condition, she is at continued risk for infection. She requires constant care and cannot be left alone. Based on the testimony of witnesses for both parties, an RN should have been involved in the Petitioner's care on at least a weekly basis due to the complexity of the Petitioner's medical needs.
16. The Respondent relied upon the evaluation of a nurse to determine the hours of skilled care needed by HASCI Waiver participants.
17. An RN can assess the Petitioner's lung functioning, skin condition, and infection risks. According to the testimony of both parties, the Petitioner would benefit from a weekly assessment conducted by an RN.
18. Due to the Petitioner's complicated medical conditions and her dependence upon a single caregiver, she should receive the maximum services available under the HASCI Waiver. For this Petitioner, a four hour block of RN services is the minimum necessary per week. However, under the current rules, the Petitioner may adjust the nursing hours between RN and LPN services. The Petitioner may therefore receive up to a maximum of 45 hours per week of RN care should she so choose, bearing in mind that limit works in tandem with the limits for LPN services and an increase in RN hours may result in a

decrease in LPN hours. Current Waiver limits are 45 hours per week of RN or 60 hours per week of LPN or some combination not to exceed \$1,425 per week.

19. The Petitioner would have benefitted from 14 hours of RN care per week through June 30, 2007, and at least four 4 hours of RN services with increased RN, if the Petitioner had desired, up to the waiver limit. The Petitioner should have received RN services weekly through the present time. The Petitioner has been maintained at home with fewer services than those to which she was entitled due to the extraordinary efforts and dedication of her mother.
20. The Petitioner's benefits should have continued at the levels ordered by her treating physician during the pendency of this appeal.
21. There are RNs available in the Petitioner's service area who will cover four hours or more of care per week.

LEGAL DISCUSSION

Medicaid recipients have due process rights prior to an adverse action impacting their Medicaid benefits. 42 C.F.R. § 431.200 *et seq.*; *Goldberg v. Kelly*, 397 U.S. 254 (1970). An action is defined as, "...a termination, suspension, or reduction of Medicaid eligibility or covered services." 42 C.F.R. § 431.201. Federal regulations require that the notice of adverse action must explain the action to be taken and the reason, cite the specific legal support for the action, explain the beneficiary's hearing rights, the right to representation, and the rights to continued benefits, and must be sent 10 days before an adverse action. 42 CFR §§ 431.206, 431.210, 431.211, 431.230. The regulations also require the agency to make available to the beneficiary the specific policy materials so that the beneficiary can determine whether to request a fair hearing and can prepare for the fair hearing. 42 CFR § 431.18(e).

The HASCI Waiver provides the same requirements regarding the availability of continued benefits that the federal regulations require. The HASCI Waiver Procedural Manual states that "the State may not reduce, deny or terminate services until a decision is rendered after the hearing. (For example, if the individual/legal guardian did not authorize a reduction of his/her Waiver services and the Waiver services are going to be reduced, the individual/legal guardian must be given written notice regarding the reduction which includes a 10 calendar day waiting period before the Waiver services are reduced. The Waiver services that were going to be reduced will continue as authorized prior to the request.)" SCDDSN Manual, Petitioner's Exhibit 6 at 5-7, emphasis in original. According to Dr. Veldheer, if a participant requests continuation of services, those services are continued through the Administrative Law Court level. T. at 51.

Medicaid eligible children, under age 21, are entitled to the screens and services provided by the Early and Periodic Screening Diagnostic and Treatment (EPSDT) provisions of the Medicaid law. 42 U.S.C. § 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). EPSDT requires that Medicaid children receive all of the medical services they need to diagnose, treat, or ameliorate their health needs regardless of whether these services are covered for adults in the state's Medicaid plan. 42 U.S.C. § 1396d(r)(5). The Petitioner turned 21 on January 14, 2009 and was entitled to EPSDT protections up until that time.

EPSDT, waiver services, medical necessity, and the role of the treating physician and the state's physician in determining medical necessity are all addressed in *Moore v. Reese* in which the Georgia agency was attempting to reduce the nursing hours of a disabled child in a waiver program. In that case, the Eleventh Circuit held that: (1) the State is required to provide medically necessary services to correct or ameliorate an illness or condition of a participant

under age 22 pursuant to EPSDT; (2) a state Medicaid plan must include reasonable standards for determining eligibility for and the extent of medical assistance; (3) a state may adopt a definition of medical necessity that places limits on a physician's discretion, but it must establish reasonable standards for physicians to use in determining what services are appropriate; (4) the treating physician assumes the primary responsibility of determining what treatment should be made available to his patients, but both the treating physician and the state have roles to play and a private physician's word on medical necessity is not dispositive; (5) a state may establish the amount, duration, and scope of Medicaid services, but the services must be sufficient in amount, duration, and scope to reasonably achieve the purpose of the program; (6) a state may place appropriate limits on a service based on such criteria as medical necessity by reviewing the medical necessity of treatment prescribed by a doctor on a case-by-case basis, and the State may present its own evidence of medical necessity in disputes between the state and Medicaid patients. *Moore v. Reese*, 637 F. 3d 1220, 1255 (11th Cir. 2011).

Upon remand, the Georgia District Court held that the attempted reduction in nursing hours violated the Medicaid Act. The District Court found the opinion of the treating physician was entitled much greater weight than that of the state's physician who had only reviewed the plaintiff's case on one occasion and relied on case summaries prepared by a nurse rather than reviewing the plaintiff's medical records. *Moore v. Cook*, Civ. Act. No. 1:07-CV-631-TWT, 2012 WL 1380220 (N.D. Ga. Apr. 20, 2012). *Royal v. Cook* also involved a disabled child receiving nursing services through a waiver program. In that case, the District Court found the reduction of nursing hours violated the Medicaid Act again determining that the treating physician's opinion was entitled to greater weight due to the state doctor's lack of any direct knowledge of the child's medical needs. *Royal v. Cook*, Civ. Act. No. 1:08-CV-2930-TWT,

2012 WL 2326115 (N.D. Ga. June 19, 2012). While the present case is factually similar to the *Moore* and *Royal* cases there is one significant variation. There was no live testimony provided by the Petitioner's treating physician; however, there was affidavit testimony along with orders by the treating physicians requiring nursing services.

Federal law requires that under HASCI and other such waivers, the state must spend less per capita than without the waiver. 42 U.S.C. § 1396n(e)(2)(B). The HASCI Waiver Document is clear that there is no individual cost limit. Respondent's Exhibit 2 at 24. Therefore, compliance with the federal law must be reached by looking at aggregate limits. The HASCI Waiver Document limits nursing services to 60 hours per week of LPN or 45 hours per week of RN or a combination of the two not to exceed the equivalent costs of either 60 hours of LPN or 45 hours of RN. The combination of attendant care and nursing care cannot exceed 10 hours per day. Respondent's Exhibit 2 at 1 and 85. The Waiver is not intended to provide around the clock care and the participant must rely, to a certain extent, on care provided by family or friends. T. at 47.

The Petitioner argues that the Waiver limits should not be applied to her based on *Olmstead v. Zimring*, 527 U.S. 581, 119 S.Ct. 2176. *Olmstead* held that the unnecessary institutionalization of individuals with disabilities violates the Americans with Disabilities Act. The Respondent argues that Waiver limits can be applied to the Petitioner based on *Olmstead's* "fundamental alteration" defense. "In evaluating a State's fundamental-alteration defense, the [court] must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably." *Olmstead* at 597.

The Petitioner also cites several additional cases in support of her arguments that Waiver limits should not be applied. She argues that the *Doe* case held that an administrative agency could not apply a rule without promulgating a regulation. However, that holding was specific to the facts of that case in which a state law that was in direct conflict with the policy at issue. In this case, there is no regulation or law which conflicts with the HASCI service limits policy for adults. *Jane Doe v. SCDHHS*, 398 S.C. 62, 727 S.E.2d 605 (SC 2011).

The Petitioner argues that *Peter B. v. Sanford* prevents the Respondent from applying the Waiver reductions. *Peter B. v. Sanford*, 2011 WL 824584 (D.C.S.C. March 7, 2011). However, *Peter B.* granted a preliminary injunction preventing a reduction in Waiver services for the three Plaintiffs in that matter. A preliminary injunction is not a dispositive ruling that the potential reduction violated the ADA or *Olmstead*. It should be noted that, two years later, the matter was dismissed as moot in the case of two of the three plaintiffs due to no actual reduction in their Waiver services. Again, the court did not find that Waiver reductions violated the ADA or *Olmstead*. *Peter B. v. Sanford*, 2013 WL 869607 (D.C.S.C. March 7, 2013).

CONCLUSIONS OF LAW

1. At the time of the appeal, the Petitioner was still hospitalized. The Respondent had denied the service hours ordered by the Petitioner's treating physician and approved a Plan of Care which provided fewer hours. The Petitioner was appealing her dispute over the decreased hours approved by the Respondent in the Plan of Care. One day after discharge, the Petitioner wrote to the Respondent to "reserve all rights." Although the subsequent reductions in service hours which the Petitioner faced were not known at the time of the letter, it is reasonable to assume her request to reserve her rights indicated that she sought continued benefits in the event of future service reductions. The skilled care

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

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

medical examination of the Petitioner at any time during the pendency of this appeal. The Petitioner should not have been subject to Waiver limits for skilled care services while under the age of 21 and should have received 28 hours per week of RN and 84 hours per week of LPN as ordered by her treating physician. These hours should have continued through the final result of this appeal.

3. Due to the complicated medical needs and fragile condition of the Petitioner, it appears as though her medical needs could exceed Waiver limits. The Petitioner argues that she should not be subject to the HASCI Waiver limits based on the cases cited above. However, these cases are distinguishable from the present case. The Respondent's September 2012 settlement letter implicitly acknowledges that it may be appropriate to exceed Waiver limits for this particular participant; however, an Administrative Hearing Officer does not have the authority to exceed the limits of the Waiver program. Since reaching the age of 21 and after the conclusion of this appeal, the Petitioner can be subject to Waiver limits and I so order.
4. Should the Petitioner experience a change in circumstances, including a worsening of her condition, she can seek additional service beyond the Waiver limits. Should she experience a service reduction, the Respondent shall provide notice and an opportunity for a hearing.

Issue 3 – How many hours of the authorized care described in #2 above, have been provided by the Petitioner's mother (according to her qualifications), and what is the cost of that care, which amount shall be paid to the Petitioner's mother.

In 2007, SCDDSN Service Coordinator told the Petitioner's mother that SCDDSN rules prohibited the Petitioner's mother from being paid for services she provided to the Petitioner

even though the Petitioner was an adult at this time. The Petitioner's mother should be reimbursed for the number of hours per week that should have been in effect based on continuation of benefits pending the final outcome of the 2007 appeal. The parties failed to provide sufficient evidence for me to determine when the Petitioner was hospitalized and how long each inpatient hospitalization lasted; therefore, I have determined that the Petitioner's mother should be paid for the hours of care provided through the first week in October, 2013 at the rate of \$11.10 per hour. The services she has provided since then until the date of this decision will offset the instances she was not providing attendant care while the Petitioner was hospitalized.

I therefore find:

1. Based on the testimony of both parties, it appears that the Petitioner's mother provided most, if not all, of the uncovered care for the Petitioner from the time she returned home until the present.
2. A family member of a Waiver participant can be paid for authorized hours of attendant care. The Petitioner's mother qualifies as an attendant caregiver.
3. The Petitioner's mother has not been compensated for the care she has provided to the Petitioner.
4. The number of Waiver and State Plan covered hours per week should have amounted to 112 hours as ordered by the Petitioner's treating physician while she was under the age of 21 and protected by the EPSDT provisions of the Medicaid program. This initial amount of ordered care should have continued during the pendency of this appeal.
5. On January 14, 2006, while still hospitalized, the Petitioner turned 18 years of age. As an adult, her parents were no longer legally responsible for her.

6. The Petitioner's mother provided attendant care services to the Petitioner. The parties are in agreement that the current payment rate for Attendant Care is \$11.10.
7. The Petitioner's mother is entitled to reimbursement for the care that she provided as follows:

Hours for Which Petitioner's Mother Shall Be Compensated

Year	Weeks	Hours Res. Should have Provided	Actual Hours Provided by Res.	Hours Provided by S.W.	Weeks x Hours Provided by S.W.	Amount Owed to S.W. at \$11.10 hour
2007	33	112	84	28	924	\$ 10,256.40
2008	27	112	84	28	756	\$ 8,391.60
2008	25	112	80	32	800	\$ 8,880.00
2009	27	112	80	32	864	\$ 9,590.40
2009	25	112	70	42	1050	\$ 11,655.00
2010	52	112	70	42	2184	\$ 24,242.40
2011	52	112	70	42	2184	\$ 24,242.40
2012	52	112	70	42	2184	\$ 24,242.40
2013	40	112	70	42	1680	\$ 18,648.00
TOTAL						\$ 140,148.60

CONCLUSIONS OF LAW

1. At all times during this appeal the Waiver provisions allowed the parents of adult children to serve as paid caregivers to those children according to their training and qualifications (Record of the 2009 Matter at 766.)
2. The rate specified for attendant care providers under the Waiver at all times during this appeal has been \$11.10.
3. The Petitioner's mother shall be reimbursed by the Respondent in the amount of \$140,148.60 for the care that she provided. The Respondent shall reimburse the Petitioner's mother within 30 days of the date of this Order.

Issue 4 – What care is the Petitioner’s mother qualified to provide within the authorized hours of service set as described in #2 above and what is the appropriate rate of pay to the Petitioner’s mother?

DISCUSSION

Due to the miscommunications described above between the parties, the Petitioner’s mother, was not aware that she could be reimbursed for the care that she has provided for the Petitioner. During the Petitioner’s lengthy hospital stay, the Petitioner’s mother learned to provide suctioning, trach care, and catheter care for the Petitioner. Petitioner’s Exhibit 13 at 3. This is skilled level care that only a nurse can provide. Even though the Petitioner’s mother does not have any formal medical training, she can provide skilled care for her daughter as a close family member and caregiver. Since the Petitioner’s mother has not trained as a nurse, the care she provides is viewed as attendant care services. The parties are in agreement that the Petitioner’s mother should be compensated at the attendant care rate of \$11.10 per hour for the services that she provides to the Petitioner when a nurse is not present. I therefore find:

1. The Petitioner’s mother is qualified to provide skilled care and attendant care services to B.W. The Petitioner’s mother has provided skilled and attendant care during the course of this appeal.
2. The current rate for attendant care providers is currently \$11.10 per hour.
3. The pay rate for attendant care may be subject to change in the future.

CONCLUSIONS OF LAW

1. Petitioner’s mother shall be paid at the rate allowed for attendant care providers which is currently \$11.10 per hour.

2. Changes to the pay rate which impact other attendant care providers will also be applied to the Petitioner's mother.
3. Whether the Petitioner's mother must be formally enrolled as a SCDDSN provider is irrelevant to my decision. However, should enrollment be requested by the Respondent in order to ensure timely payment to the Petitioner's mother, the Petitioner's mother shall be afforded all assistance necessary to hasten her enrollment as a SCDDSN provider. Any enrollment process that may be requested shall not prevent the Petitioner's mother from receiving reimbursement for services previously and currently provided.

Issue 5 – What is the cost of an average digital speech device to be paid to the Appellant to defray the cost of the device she purchased?

DISCUSSION

The Petitioner is unable to speak effectively due to injuries to her larynx subsequent to the automobile accident which rendered her quadriplegic. In January 2007, while at MUSC, she was evaluated for a speech generating device and the device was ordered by her physician at the hospital. The device was subject to a prior authorization review by the Medical Director of SCDHHS who found that a less expensive device was appropriate. In March 2007, the Respondent sent a notice that the prior authorization could not be processed stating: "Per our medical consultant, this is not medically necessary or rehabilitative." Petitioner's Exhibit 22. The notice was sent to the durable medical equipment (DME) provider, not the Petitioner. The notice did not state a statute or regulation upon which the decision was based nor did it provide any information regarding the Petitioner's right to appeal the decision. On April 12, 2007, the SCDDSN Service Coordinator wrote to the Petitioner's attorney stating that the HASCI Waiver will pay for assistive technology for the Petitioner once she comes home. Exhibit 3 to

Petitioner's Exhibit 12 (Affidavit of B.W.). On April 24, 2007, Dr. Teresa Cuoco ordered an alternative speech generating device for the Petitioner. On April 25, 2007, Dr. Pamela Pride signed the certificate of medical necessity for this speech generating device. On May 21, 2007, the Respondent notified the DME provider, Dynavox, that the prior authorization request would not be processed. Again, the Respondent informed only the DME provider and not the Petitioner. As with the previous notice, this notice did not state a statute or regulation upon which the decision was rendered nor did the notice provide any information regarding the Petitioner's right to appeal the decision. The Petitioner was under 21 at the time that her treating physicians ordered the speech generating devices and was subject to the protections of EPSDT which allowed her to receive treatment to correct or ameliorate defects and physical illnesses. 42 U.S.C. 1396d(r)(5). According to the Respondent's witness, Ms. Mohamed, the Medicaid program covers speech augmentative devices and covered the particular device that was ordered by the Petitioner's doctor. T. at 119. The entire package of the speech generating device and the covered attachments would have cost the Respondent, "a little over \$8,000." T. at 125. In 2008, after the delays and miscommunications noted above, the Petitioner purchased a speech generating device herself at a cost of \$12,217.70.

The Petitioner testified, via affidavit, that she is frustrated by her inability to communicate which has isolated her and contributed to her depression. Petitioner's Exhibit 12. Ms. Galus, testified that the Petitioner's current speech device requires her to attach a small metal disk to her forehead to use the device. The Petitioner has become allergic to the adhesive used to attach the disk to her forehead. Ms. Galus further testified that the Petitioner is unable to wear her eye glasses when using the device which causes her to suffer migraine headaches. The migraines and the allergies limit the amount of time the Petitioner can use the speech device.

Witnesses for the Petitioner testified that it is possible to obtain speech generating devices which utilize eye gaze technology and do not require an adhesive dot to be attached to the individual's forehead. The Respondent's witness, Ms. Mohammed, testified that there was no set schedule of how often replacement speech devices can be authorized. Authorization of a new device depends on medical necessity. T.at 132. Ms. Wingo, the current Service Coordinator, was also questioned regarding the Petitioner's need for a replacement communication device, to which she responded, "that's outside my scope of job – outside my job description." T at 115.

As the Respondent would have approved a less expensive speech generating device, the Administrative Law Court has determined that the Respondent pay the Petitioner the amount that would have been paid for a digital device in order to defray the cost of the device that the Petitioner purchased. I therefore find:

1. The Petitioner was eligible to receive a speech generating device at the time her doctor ordered it and the Medicaid program covered such devices.
2. A speech generating device and the covered attachments that would have met the Petitioner's needs and her doctor's order would have cost slightly more than \$8,000.00.
3. The Respondent has offered to pay the Petitioner \$8,318.80 to defray the cost of the speech generating device that was purchased by the Petitioner outside of the Medicaid program.
4. The offer of \$8,318.80 is fair based upon the types of devices and attachments covered by the Respondent. This offer is consistent with the cost of such devices and attachments.

CONCLUSIONS OF LAW

1. The Petitioner's mother shall be reimbursed \$8,318.80 to defray the cost of the speech device which she purchased.

2. The Respondent shall reimburse the Petitioner's mother within 30 days of the date of this Order.
3. Whether the cost of the device is covered by the Waiver or by the State Plan is irrelevant to my decision and shall be determined by the Respondent and its agent, SCDDSN. That determination shall not impact or delay the reimbursement of the \$8,318.80 owed to the Petitioner's mother.
4. This Order does not prevent the Petitioner from seeking the difference between the amount awarded here and the actual cost her family incurred. Nor does this Order prevent the Petitioner from seeking an assessment for a new speech generating device or a replacement speech generating device in the future. Should a future medical order for a speech generating device by the Petitioner's provider be denied or reduced by the Respondent, the Respondent shall send the Petitioner notice of such denial or reduction allowing the Petitioner the opportunity to appeal.


DECISION

1. The Petitioner shall receive RN, LPN, and Attendant Care services to the extent allowable under HASCI Waiver limits. She may receive 45 hours per week of RN or 60 hours per week of LPN or a combination of the two not to exceed the costs of RN care. She may combine attendant care with these hours to receive a maximum of 10 hours of nursing and attendant care per day. The Petitioner shall determine the mix of services she shall receive and those hours shall be flexible depending on her needs and the availability of providers in her area. The Service Coordinator shall assist the Petitioner in securing these services.

2. The Petitioner's mother may provide some of the hours of care required under the Petitioner's Service Plan. If the Petitioner's mother provides such care, she shall be paid for that care at the rate for Attendant Care Services (currently \$11.10 per hour).
3. The Petitioner's mother shall be repaid in the amount of \$140,148.60 for the care she provided to the Petitioner during the pendency of this appeal. This amount shall be paid to the Petitioner's mother within 30 days of the date of this Order.
4. Within 30 days of the date of this Order, the Respondent shall reimburse the Petitioner's mother \$8,318.80 for the cost of the speech generating device.

Any issues not addressed in this Order are deemed dismissed.

AND IT IS SO ORDERED.


Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina

November 19, 2013

Exhibit 2 B.W. v. DHHS, December 23, 2014

December 23, 2013

Patricia Harrison, Esquire
611 Holly Street
Columbia SC 29205
VIA CERTIFIED MAIL

Richard G. Hepfer
Deputy General Counsel
South Carolina Department of Health and Human Services
VIA ELECTRONIC DELIVERY

RE: Order in Response to Respondent's Motion for Reconsideration
Matter of Brook Waddle v. SCDHHS
Appeals' Case # 07-MISC-028
Medicaid # 6780499394

Dear Ms. Harrison and Mr. Hepfer:

Enclosed, please find the Order in Response to Respondent's Motion for Reconsideration in the above-referenced matter.

Sincerely,

Elizabeth B. Hutto

Elizabeth B. Hutto
Program Director, Division of Appeals and Third Party Liability
Interim CFO, SCDHHS

EBH/ss
Enclosures (2)

STATE OF SOUTH CAROLINA	)	BEFORE THE DIVISION OF
	)	APPEALS AND HEARINGS
COUNTY OF RICHLAND	)	SOUTH CAROLINA DEPARTMENT OF
	)	HEALTH AND HUMAN SERVICES
B.W.,)	
)	
Petitioner,	)	ORDER
	)	RESPONDENT'S MOTION FOR
-v-	)	RECONSIDERATION
)	
South Carolina Department of Health)	
and Human Services,	)	Appeals' Case #: 07-MISC-028
	)	(Remanded)
Respondent.)	
_____)	

BACKGROUND

On November 19, 2013, the Final Administrative Decision was issued in this matter. The history of this case was described therein. In response, the Respondent filed a Motion for Reconsideration on December 2, 2013. As of the undersigned date, the Petitioner has failed to respond to the Respondent's Motion.¹ In essence, the Respondent asserts error in the conclusion of law that the Petitioner was entitled to continued benefits at the level that her physicians ordered during the pendency of this appeal. The Respondent makes three requests for relief of the undersigned Hearing Officer as follows:

- "1. Correct the erroneous conclusion of law that when a denial of services is appealed, that the denied services must continue until a decision is rendered on the appeal;
2. Consequently find that, in this case, the appeal, and therefore the requirement to maintain services, did not initially apply to the reductions in services; and
3. Therefore, that under Judge McLeod's directions in this matter that the formally published Waiver limitations (not the ones informally applied by the Departments) should be used to determine the amount of the waiver services that should have been provided since discharge from the hospital."

¹ Note, on December 16, 2013, an email from the Petitioner's Attorney was received by the undersigned Hearing Officer. In that email, the Attorney for the Petitioner explained that, "[M]y assistant of 20 years retired recently and Rick's motion appears to have been misfiled in my office." An email sent two days later clarified that the legal assistant had retired in September.

(Respondent's Motion for Reconsideration at 4)

DISCUSSION

The Respondent asserts that the Final Administrative Decision errs by interpreting 42 C.F.R. § 431.230 as applying to a denial when the language in the regulation speaks only of terminations or reductions of services. I disagree with the assertion that the regulation has been misinterpreted.

In this case, the Petitioner, as advised by her treating physicians stated she needs 112 hours of total care per week. The Respondent, despite not visiting or examining the Petitioner, insisted on fewer hours of skilled care and denied the request for 112 total hours even though this would have been sharply less than the round-the-clock RN hours received during the initial hospitalization that lasted for approximately a year and a half. After many months of delays, the Petitioner was forced to accept the Respondent's proposed hours if she wanted to return home. There was no viable alternative. The Respondent's assertion that this appeal is about a denial of services does not hold up. Clearly, the dispute is over a reduction of services.

In their first request for relief, the Respondent seems to express concern that the asserted misinterpretation of 42 C.F.R. § 431.230 would allow every Medicaid beneficiary who requests a "new service," and who appealed, to receive the service until a hearing decision could be rendered on his request. I believe this concern is misplaced for the reasons stated above. There was never any question that the Petitioner was entitled to, and needed, skilled nursing care. Skilled nursing care was not a "new service" for this Petitioner.

The Respondent's second request that the waiver limits be applied to the Petitioner during the pendency of this appeal cannot be realized due to the Respondent's failure to provide adequate notice of any of the reductions that were applied to the Petitioner. This failure violated the Petitioner's due process rights. When a recipient requests a hearing, the agency may not

terminate or reduce services until a decision is rendered after the hearing unless the agency “promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.” 42 CFR §431.232 (emphasis added). Finally, the hearing must cover “agency decisions regarding the type or amount of services.” 42 CFR §431.241 (emphasis added). Even if the Respondent had the discretion to subject the Petitioner to service reductions during the pendency of this appeal, the facts bear out that reductions were executed without prior written notice. These reductions were improper because they violated the Petitioner’s due process rights.

The Respondent’s third request is based upon an interpretation of the language in the second issue articulated in the July 30, 2012 Remand of the Administrative Law Court. That issue stated:

“The specific type of care and number of weekly hours of each type of care required by the Petitioner during the course of her treatment since her discharge from the hospital in May of 2007 consistent with the Medicaid Program, and the principle that the mother is not legally responsible for caring for the Petitioner.”

The Respondent argues that Judge McLeod’s language “consistent with the Medicaid Program,” means “within the formal waiver limits.” I disagree. It seems that had the Administrative Law Judge intended that the formal waiver limits should have applied throughout the appeal, that specific language would have been used. It appears more likely that, “consistent with the Medicaid Program,” refers to due process, the delivery of medically necessary services, EPSDT protections, and all other state and federal requirements of Medicaid program.

ORDER

For the foregoing reasons, the Respondent's Request for Reconsideration is hereby denied. The Final Administrative Decision of November 19, 2013 stands.

AND IT IS SO ORDERED.

Elizabeth B. Hutto

Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina

December 23, 2013

Exhibit 3 B.W. v. DHHS, Response to DHHS' Motion filed May 1, 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.

RESPONSE TO DHHS' MOTION FOR AN EXTENSION OF TIME
TO FILE INITIAL BRIEFS AND PETITION FOR AN ORDER
OF CONTEMPT AND RULE TO SHOW CAUSE

I. Response to DHHS Request for Extension.

This Response is provided in response to DHHS' Motion for an Extension of Time to file briefs. Counsel for Brook Waddle intended to provide counsel for DHHS conditional consent to Respondent's Motion for an Extension. As a condition for the consent, Brook requested that services ordered by Hearing Officer Hutto be provided during the appeal, as required by her order. Exhibit 1. Out of fairness, Brook requests that any extension granted to DHHS to file an initial brief be also granted to her.

II. Motion for Order of Contempt and Rule to Show Cause.

In addition, Brook respectfully petitions this Court to immediately order DHHS to comply with the order of hearing officer Hutto while this appeal is pending. Brook petitions this Court for an order holding DHHS in contempt and a Rule to Show Cause.

Brook has quadriplegia, she breathes through a tracheostomy and her condition is life

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MAY 01 2014

threatening. *Brook Waddle v. DHHS*, Case No. 07-MISC-028, November 19, 2013. Exhibit 2. She is likely to suffer irreparable injury if this Court does not accept and rule upon this Petition. The Executive Branch has prevented judicial review of Brook's appeals for more than six years and DHHS has violated not only federal laws and regulations contained in the Medicaid Act, but an order of its own hearing officer and the July 2011 Order of this Court. Since she was released from the hospital in 2007, Brook 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. She has to be suctioned throughout the day and is at risk of aspiration. Brook now has seizures, which she never experienced when she was receiving nursing services in the hospital, and since 2012, she has experienced periods of mental confusion which were not present before her release from the hospital in 2007, when she was receiving around-the-clock nursing services.

For more than six years, DHHS refused to provide the services her treating physicians have all determined, since 2007, to be medically necessary. Hearing Officer Hutto recognized that the agency has not based its decisions on any physician's order or the personal examination of any qualified medical source. While Brook's case was on appeal to DHHS and the Administrative Law Court, without providing notice of her right to appeal the reduction in services, DHHS reduced her services below the number of hours she was receiving when she filed the 2007 appeal.

This Court is bound to enforce South Carolina Code of Laws § 1-23-380, which provides that "...the serving and filing of the notice of appeal does not itself stay enforcement of the agency decision." DHHS has not filed a motion to request a stay pursuant to Rule 65 of the South Carolina Rules of Civil Procedure. Justice demands, as a matter of law and equity, DHHS should

be ordered to immediately comply with the Order of its own agency hearing officer.

The South Carolina Court of Appeals has ruled that "A party may be found in contempt for the willful violation of a lawful court order." *Hawkins v. Mullins*, 359 S.C. 497, 501, 597 S.E.2d 897, 899 (Ct.App.2004). The South Carolina Supreme Court has stated that: "A willful act is one ... done voluntarily and intentionally with the specific intent to do something the law forbids, or with the specific intent to fail to do something the law requires to be done; that is to say, with bad purpose either to disobey or disregard the law." *Ex parte Lipscomb*, 398 S.C. 463, 469, 730 S.E.2d 320, 323 (Ct.App.2012) (quoting *Ex parte Cannon*, 385 S.C. 643, 661, 685 S.E.2d 814, 824 (Ct.App.2009)). The Supreme Court has ruled that "Once the moving party has made out a prima facie case [for contempt], the burden then shifts to the respondent to establish his ... defense and inability to comply with the order." *Id.* "The Supreme Court recognized that "A good faith attempt to comply with the court's order, even if unsuccessful, does not warrant a finding of contempt." *Lipscomb*, 398 S.C. at 470, 730 S.E.2d at 324. But in this case, the agencies have made no good faith attempt to comply with Hearing Officer Hutto's order and DHHS should be required to show cause for its willful violation of the order of DHHS and this Court's 2011 order.

S.C. Code Ann. § 1-23-630 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 Court clearly has the authority to issue an order of contempt. *South Carolina Department of Labor v. Scruggs*, 102513 SCALC, 11-ALJ-11-0264-IJ, October 25, 2013. On August 1, 2013, this Administrative Law Judge issued a Rule to Show Cause, Order to Answer Petition for Injunctive Relief and Notice of Hearing for Injunctive Relief. That order required the

Respondents to Answer the Petition by July 29, 2013. Two days later this Court issued an order enjoining Scruggs from continuing to violate the law. Surely, requiring the agency to save the life of Brook is as important as enjoining someone from providing unlicensed funeral services.

On July 25, 2012, the appellant in *Mary L. Dinkins Higher Learning Academy v. South Carolina Public Charter School District* filed a Rule to Show Cause motion alleging the Board's violation of the automatic stay imposed under ALC Rule 34. 050313 SCALC, 12-ALJ-30-0281-AP, May 3, 2013. This Court held a hearing two days later. *Id.*

But, seven years after Brook Waddle filed her administrative appeal, she still has not been provided judicial review and her case remains logjammed in the Executive Branch.

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 McLean's Order, to her mother pursuant to the order of Judge McLeod.

Respectfully submitted,



Patricia Logan Harrison

611 Holly Street

Columbia, South Carolina 29205

803 256 2017

plh.cola@att.net

May 1, 2014

Exhibit 1

Emails

plh.cola@gmail.com

From: <plh.cola@gmail.com>
Date: Monday, April 28, 2014 4:05 PM
To: "Damon Wlodarczyk" <damonw@rplfirm.com>
Subject: Re: W.

Damon, we will consent to an extension, but DHHS needs to go ahead and provide the services that have been ordered during the interim. The record in this case is 18 volumes. I've got a deadline today, but if you call me tomorrow, I'll be happy to discuss.

We have both filed appeals and the order needs to refer to both sides as Appellant/Respondent.

Also, I've asked about dates for Stogsdill depositions, but I don't think I've received a response. We'll go ahead and file notices if I don't receive convenient dates from you in next couple of days.

Trisha

From: Damon Wlodarczyk
Sent: Monday, April 28, 2014 3:17 PM
To: plh.cola@gmail.com
Cc: Rick Hepfer
Subject: RE: W.

Trisha:

DHHS has asked me to handle a couple of matters including the once discussed below. I received the file while on vacation and met with Rick today but have not had time to review the file materials. I was planning to seek a 45 day extension to serve the brief, currently due Friday. Rick informed me that you also filed an appeal but was not provided information regarding the briefing deadline. I would propose a filing a joint motion to extend the briefing deadlines in both appeals by 45 days. Please let me know if you're amenable and I'll prepare something for review. I'm out of the office beginning Wednesday so I would like to get something off tomorrow afternoon.

Thanks,

Damon C. Wlodarczyk
Attorney and Counselor at Law
Riley Pope & Laney, LLC
2838 Devine Street
Post Office Box 11412 (29211)
Columbia, South Carolina 29205
Office: 803-799-9993
Facsimile: 803-239-1414
E-mail: damonw@rplfirm.com
Web: www.rplfirm.com

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From: plh.cola@gmail.com [mailto:plh.cola@gmail.com]

Sent: Sunday, April 27, 2014 9:50 PM

To: Rick Hepfer

Subject: W.

Rick, Mr. Lenski's order identifies B.W. as the Respondent and I've got your brief being due this Friday, with mine due in 30 days. In reviewing Mr. Lenski's order, he mentions your notice of appeal, but not ours, which was filed on Dec. 18, 2013. I'm confused. What is your understanding of the briefing schedule?

Thanks.

T.

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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.

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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). *Shakhmes*, *Id.* Of great importance in this case are the instructions in *Shakhmes* 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 & Env'tl. 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 take 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

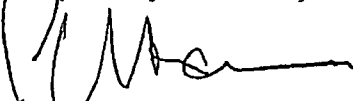
circuit court judges and to issue those remedial writs as are necessary to give effect to its jurisdiction." (2005) (emphasis added). This power is in addition to the power to hold DHHS in contempt and enforcement of Hearing Officer Hutto's order does not require a finding of willful contempt. (Although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



Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
803 256 2017
plh.cola@att.net

Kenneth C. Anthony, Jr.
250 Magnolia Street
Spartanburg, South Carolina
864 582 2355
kanthony@anthonylaw.com

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

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

TELEPHONE (803) 256-2017

FAX (803) 256-2213

June 23, 2014

Hand Delivery

Clerk's Office
Administrative Law Court
Edgar A. Brown Building, Suite 224
1205 Pendleton Street
Columbia, South Carolina 29201

RE: Brook Waddle v. SCDHHS
Docket No. 13-ALJ-08-0603-AP

Dear Clerk:

Enclosed is a Petition/Complaint for filing in the above-referenced matter. Please clock the copy and return.

Also enclosed is a copy of the letter being sent to the Attorney General, along with a copy of the Petition/Complaint

Cordially,



Patricia L. Harrison

cc: Attorney General Alan Wilson
Brook Waddle
Kenneth Anthony, Esq.
Richard Hepfer, Esq.
Damon Wlodarczyk

FILED

JUN 23 2014

SC ADMIN. LAW COURT

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

TELEPHONE (803) 256-2017

FAX (803) 256-2213

June 23, 2014

The Honorable Alan Wilson
Office of the Attorney General of South Carolina
Rembert Dennis Building
1000 Assembly Street, Room 519
Columbia, SC 29201

Dear Attorney General Wilson:

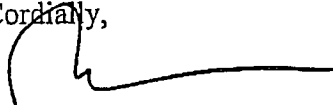
Enclosed is a Petition/Complaint which has been filed in the South Carolina Administrative Law Court in *Brook Waddle v. DHHS*. As in the *Linkhorn* case, DDSN (and DHHS) are refusing to provide the services which have been ordered. In Brook's case, we filed an administrative appeal in 2007. Her case has cycled and recycled between DHHS and the Administrative Law Court for more than seven years now.

We asked the Administrative law Judge to enforce the order of the DHHS hearing officer several months ago, but it appeared at the hearing on that motion that he did not consider our request to be properly framed. Out of an abundance of caution, we are serving the Attorney General with our Petition/Complaint.

Brook's condition continues to deteriorate and she is at great risk of harm if the requested services are not provided. I am available to meet with you to discuss this case and other cases in which DDSN/DHHS have not provided services with reasonable promptness, as required by the Medicaid Act. (See *Doe v. Kidd I* and *Doe v. Kidd II*. In that case, we have filed our third appeal to the Fourth Circuit and the residential habilitation services that the Court ordered in 2011 have still not been provided.)

I can be reached at 803-360-5555.

Cordially,



Patricia Logan Harrison

c: Brook Waddle
Ken Anthony, Esq.

FILED

JUN 29 2014

SC ADMIN. LAW COURT

THE 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.

SUMMONS

TO THE RESPONDENT/APPELLANT ABOVE NAMED AND THE ATTORNEY GENERAL
FOR THE STATE OF SOUTH CAROLINA:

YOU ARE HEREBY SUMMONED and required to answer the Petition/Complaint herein, a copy of which is herewith served upon you, and to serve a copy of your answer to this complaint upon the subscriber, at the address shown below, within thirty (30) days after service hereof or as sooner directed by the Administrative Law Court, exclusive of the day of such service, and if you fail to answer the petition/complaint, judgment by default will be rendered against you for the relief demanded in the complaint.

Honorable Alan Wilson
P.O. Box 11549
Columbia, S.C. 29211

SOUTH CAROLINA ATTORNEY GENERAL

Damon Wlodczarck
Riley Pope and Laney
2838 Devine Street
Columbia, SC 29205

ATTORNEY FOR RESPONDENT



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

ATTORNEY FOR APPELLANT

Jun 20, 2014

FILED

JUN 23 2014

SC ADMIN. LAW COURT

Exhibit 5 B.W. v. DHHS, Motion to Dismiss Petition/Complaint
for Remedial Writ filed July 23, 2014

COPY

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Brook Waddle,

Appellant/Respondent,

v.

South Carolina Department of Health and
Human Services,

Respondent/Appellant.

Docket No. 14-ALJ-08-0603-AP

**MOTION TO DISMISS
PETITION/COMPLAINT FOR
REMEDIAL WRIT**

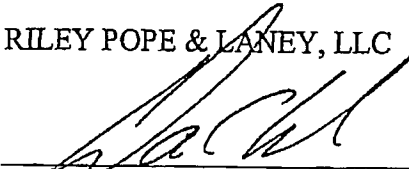
The Respondent/Appellant (hereinafter "SCDHHS") hereby moves as allowed by Rule 19 of the Rules of Procedure for the Administrative Law Court, for an Order dismissing the document captioned Petition/Complaint for Remedial Writ on the following grounds:

- 1) the Petition exceeds the statutory authority of this Court;
- 2) the Petition appears to seek a determination of matters raised on appeal;
- 3) the Petition re-raises issues of allegations of wrongdoing and an award of sanctions which were previously raised to this Court, which were denied by Respondent/Appellant;

This motion is further based upon the laws, rules and statutes of the State of South Carolina, the pleadings filed in this matter, and such other material as this court may deem just and proper.

Signature Block Appears on Following Page

RILEY POPE & LANEY, LLC



Damon C. Wlodarczyk, S.C. Bar 70460
Post Office Box 11412
Columbia, South Carolina 29211
Telephone: (803) 799-9993
Facsimile: (803) 239-1414
Attorneys for Respondent/Appellant

Columbia, South Carolina
July 23, 2014

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, chief Administrative law judge

Appellate Case No. 2013-002415

Brook Waddle,

Appellant,

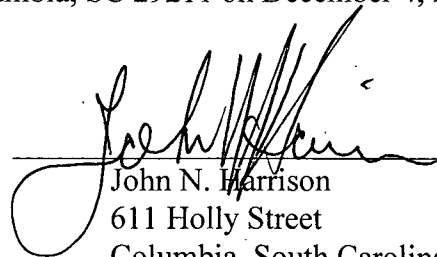
v

South Carolina Department of Health
and Human Services,

Respondent.

CERTIFICATE OF SERVICE

John N. Harrison certifies that he has served the enclosed *Appellant's Response to Motion to Dismiss* in the above captioned case by US Mail to Damon C. Wlodarczyk, Esq., Riley, Pope & Laney, LLC, PO Box 11412, Columbia, SC 29211 on December 4, 2014.



John N. Harrison
611 Holly Street
Columbia, South Carolina 29205
(803) 256-2017

RECEIVED

DEC 09 2014

SC Court of Appeals

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

TELEPHONE (803) 256-2017

FAX (803) 256-2213

December 4, 2014

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

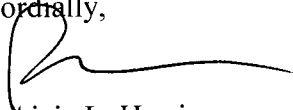
RE: **Brook Waddle v. SC Department of Health and Human Services**
Appellate Case No. 2013-002415

Dear Ms. Kitchings:

Enclosed is the original *Appellant's Response to Motion to Dismiss* along with six copies and a Certificate of Service. Please clock the copies of this letter, the Certificate of Service and Page 1 of the *Response*, and return them in the stamped envelope provided.

Thank you for your consideration and assistance in this matter.

Cordially,



Patricia L. Harrison

Enclosures
PLH:jnh

c: Damon C. Wlodarczyk, Esquire
Riley Pope & Laney, LLC
PO Box 11412
Columbia, SC 29211

Kenneth C. Anthony, Jr., Esq.
The Anthony Law Firm
PO Box 3565
Spartanburg, SC 29304-3565

RECEIVED
DEC 08 2014
SC Court of Appeals



FROM:

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

RECEIVED
DEC 09 2014

TO:

The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
1015 Sumter Street
PO Box 11629
Columbia, South Carolina 29211

SC Court of Appeals