THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

The Hon. Shirley C. Robinson, Administrative Law Judge
Trial Court Case No. 2012ALJ080173AP

Albert C. Myers, ... Appellant,

v.

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

Appellate Case No. 2014-000418

FINAL INITIAL BRIEF OF APPELLANT

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

ATTORNEY FOR APPELLANT

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I. STATEMENT OF ISSUES ON APPEAL

Issue 1. **Did the agency violate Myers' due process rights and 42 C.F.R. 431.210(b), and did Respondent's notice contain the required "reasons for the intended action" and the statute or regulation that the agency relied upon to support action taken? Is this violation subject to repetition, yet it has evaded review?**

Issue 2. **Are the reductions and terminations of Medicaid services Myers complained of in this appeal unenforceable because they were not promulgated as regulations pursuant to the South Carolina Administrative Procedures Act?**

Issue 3. **Did the agency err in its determination that the services ordered by Myers' physician were not medically necessary because Respondent failed to provide any evidence from a qualified source that contradicted the orders of Myers' physician and the evidence from other qualified sources presented at the hearing?**

Issue 4. **Did the hearing officer and the lower court err in its finding that Respondent did not retaliate against Myers and his guardian in violation of the anti-retaliation provisions of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act and the Civil Rights Act?**

II. STANDARD OF REVIEW

The standard of review for Medicaid appeals is governed by the Administrative Procedures Act. S.C.Code Ann. § 1-23-380(5) (Supp.2010). *Jane Doe v. DHHS,* 398 S.C. 62, 71, 727 S.E.2d 605, 609 (S.C. 2011). The Court may affirm the agency's decision, remand the matter, or reverse or modify the lower court's order if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are: (a) in violation of constitutional or statutory provisions; (b) in excess of the statutory authority granted of the agency; (c) made upon unlawful procedure; (d) affected by other error of law; (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or (f) arbitrary or capricious or

characterized by abuse of discretion or clearly unwarranted exercise of discretion. *Id.*

In this case, Myers seeks injunctive relief to prevent Respondent from imposing binding norms that have not been promulgated as regulations under the guise that he does not need the services at issue in this appeal. "Actions for injunctive relief are equitable in nature." *Shaw v. Coleman*, 373 S.C. 485, 492, 645 S.E.2d 252, 256 (Ct. App.2007). *See also* Jean Hoefer Toal, et al., *Appellate Practice in South Carolina* at 193 (1999). In equitable actions, the appellate court may review the record and make findings of fact in accordance with its own view of a preponderance of the evidence. *See Ingram v. Kasey's Assocs.,* 340 S.C. 98, 105, 531 S.E.2d 287, 290-91 (2000); *Townes Assocs. v. City of Greenville,* 266 S.C. 81, 85, 221 S.E.2d 773, 776 (1976). In actions in equity this Court may find facts in accordance with its own view of the preponderance of the evidence. *Shaw* at 492.

"Substantial evidence is not a mere scintilla; rather, it is evidence which, considering the record as a whole, would allow reasonable minds to reach the same conclusion as the agency." *Friends of Earth v. Pub. Serv. Comm'n of S.C.*, 387 S.C. 360, 366, 692 S.E.2d 910, 913 (2010). An appellate court may reverse the decision of the ALC if it is affected by an error of law or is "arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion." *S.C. Dep't of Motor Vehicles v. Blackwell*, 389 S.C. 293, 295, 698 S.E.2d 770, 771 (2010) (quoting S.C. Code Ann. § 1-23-610(B) (Supp. 2008)).

"Statutory interpretation is a question of law." *Hopper v. Terry Hunt Constr.,* 373 S.C. 475, 479, 646 S.E.2d 162, 165 (Ct.App.2007). This court may decide matters of law with

no particular deference to the lower court. *Pressley v. REA Constr. Co.,* 374 S.C. 283, 287-88, 648 S.E.2d 301, 303 (Ct.App.2007). Particularly, in a case raising a novel question of law regarding the interpretation of a statute, the appellate court is free to decide the question with no particular deference to the lower court. *I'on, L.L.C. v. Town of Mt. Pleasant,* 338 S.C. 406, 411, 526 S.E.2d 716, 719 (2000) (citing S.C. Const. art. V, §§ 5 and 9 ; S.C.Code Ann. §§ 14-3-320 and -330 (1976 & Supp.2005), and S.C. Code Ann § 14-8-200 (Supp.2005)); *Osprey, Inc. v. Cabana Ltd. Partnership*, 340 S.C. 367, 372, 532 S.E.2d 269, 272 (2000) (same); *Clark v. Cantrell,* 339 S.C. 369, 378, 529 S.E.2d 528, 533 (2000) (same). "The appellate court is free to decide the question based on its assessment of which interpretation and reasoning would best comport with the law and public policies of this state and the Court's sense of law, justice, and right." *Sloan v. South Carolina Bd. of Physical Therapy Examiners*, 370 S.C. 452, 636 S.E.2d 598 (S.C. 2006). Citing *Croft v. Old Republic Ins. Co.,* 365 S.C. 402, 408, 618 S.E.2d 909, 912 (2005) ; *Antley v. New York Life Ins. Co.,* 139 S.C. 23, 30, 137 S.E. 199, 201 (1927) ("In [a] state of conflict between the decisions, it is up to the court to 'choose ye this day whom ye will serve'; and, in the duty of this decision, the court has the right to determine which doctrine best appeals to its sense of law, justice, and right.")

III. STATEMENT OF THE CASE

Myers filed this appeal in December of 2010, when his service coordinator informed him that his Medicaid services would be reduced on January 1, 2010. R. 686. The only written "notice" in the Record is a generic letter Respondent's agent, the South Carolina Department of Disabilities and Special Needs (DDSN), claims to have sent to all

Medicaid waiver participants. R. 632. This "notice" did not contain the statutes or regulations relied upon. Id. The only "reason" provided on this "notice" was that the Centers for Medicare and Medicaid Services (CMS) had approved the changes which would go into effect on January 1, 2010." Id.

Myers' original letter of requesting reconsideration by DDSN is not contained in the Record on Appeal.[1] DDSN denied Myer's request for reconsideration in a letter dated January 13, 2010. R. 2 and R. 686. In this denial, the director of DDSN stated that the reductions were necessary due to "devastating state budget reductions."[2] R. 686. This letter stated that:

> These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants...we are not at liberty to exceed the established limits.

Id. This letter informed Myers that his physical therapy services would be eliminated and other services would be reduced. Id.

Myers filed an appeal with the DHHS Office on Hearings and Appeals on February 11, 2010 and she requested that the hearing be held in Camden, South Carolina. R. 687.

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In Medicaid appeals, the Record on Appeal is prepared by the DHHS Office of Hearings and Appeals, not the Appellant. Appellant objected to the Record on Appeal not being complete in her brief filed with the Administrative Law Court, but that Court did not require DHHS to supplement the Record. Appellant's ALC brief at 1.

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But at the hearing, Respondent failed to produce any evidence that the funding available for the MR/RD Medicaid waiver program had actually been reduced, or that providing the services Myers requested would fundamentally alter the State's system or that providing the requested services in Myers' home would actually cost more than his care in an institution. In any event, this "reason" was not contained on the "notice" provided to MR/RD Medicaid waiver participants upon which this appeal is based.

On February 18, 2010, Jacob Chorey of DDSN sent the Office of Appeals and Hearings an *ex parte* memo describing the agency's position on the appeal. R. 688. Chorey sent a second *ex parte* memo to the Office of Hearings and Appeals on February 24, 2010. R. 689. This memo was not provided to Appellant until he received the Record from the hearing officer, after the agency's second opinion on remand from the Administrative Law Court was issued.

The day after Chorey's second memo was received, on February 25, 2010, instead of scheduling an evidentiary hearing, the DHHS hearing officer issued an "interlocutory" order which required Appellant to provide, in writing, evidence of errors. R. 2 and 58. Myers filed a response to the interlocutory order on March 15, 2010 setting forth his grounds for the appeal. R. 61. Myers' counsel reiterated his requested that the hearing be held in Camden in a letter dated March 15, 2010. R. 691. DHHS filed a reply to Myers' response on March 30, 2010. R. 67.

Not satisfied with Myers' written response, on May 6, 2010, the hearing officer dismissed Myers' appeal, without providing an evidentiary hearing. R. 51. Myers filed a motion to reconsider on May 21, 2010. R. 75. But that motion was omitted from the Record by DHHS.[3] R. 2. On June 18, 2010, Myers filed a Notice of Appeal in the ALC,

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[3] As discussed on Myer's ALC brief dated August 2, 2012, documents filed in Myers' appeal between May 6, 2010 and November 9, 2011 have been omitted from the Record on Appeal. Appellant's ALC brief at 1 and 2. These omitted documents include (1) Myers' May 21, 2010 Motion to Reconsider the May 6, 2010 order, (2) DHHS's September 24, 2010 Cross-Motion to Dismiss Myer's appeal, (3) ALC October 4, 2010 order consolidating cases, (5) Myers' October 12, 2010 Reply to this Cross Motion. Also omitted were the consolidated Appellants' ALC brief dated February 22, 2011, DHHS' ALC brief dated March 22, 2011 and the consolidated Appellant's reply brief dated April

but DHHS did not include that notice in the Record. R. 2.

On September 13, 2010, Myers, along with Michelle M., Chip E. and Susan E. filed a motion to consolidate their appeals in the ALC. R. 81-91. On September 24, 2010, Respondent filed a cross-motion in the ALC asking that court to dismiss Myer's appeal. R. 182. Neither the Administrative Court Rules nor the South Carolina Administrative Procedures Act contain authority allowing the Administrative Law Court to dismiss an appeal from a final agency decision. The briefs filed by Appellant and the brief of Respondent are not included in the Record filed by DHHS on the second appeal to the ALC.

By order dated October 4, 2010, the ALC consolidated Myers' appeal with those of the other three appellants, who also appealed the legality of the Medicaid service reductions and other violations of the Medicaid Act and the ADA. R. 49. But not included in the record is Appellant's response to this motion to dismiss filed on October 12, 2010.

On November 9, 2011, the Administrative Law Court issued an order remanding the consolidated case back to DHHS. R. 33. The Appellants filed a Motion to Reconsider the ALC order on November 21, 2011 (not included in the Record on Appeal), which was denied by order of the ALC on December 6, 2011. R. 31.

On December 9, 2011, the consolidated case Appellants again objected to Respondent's violation of the Medicaid regulation that requires specific information to be contained in their notices and the Appellants requested a conference to determine what

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4, 2011.

issues might be addressed at the hearings, so that they could adequately prepare for the hearing.[4] (Inadvertently omitted by Appellant from Record, will file motion to supplement Record). Specifically, the Appellants complained of not having been provided with notices containing the statute or regulation Respondent relied upon and not identifying "what issues will be heard and the basis for what unknown actions HHS may intend to take."

The DHHS Office of Hearings and Appeals scheduled four separate hearings on January 3, January 4, January 5 and January 6 for the four consolidated case appellants, although no order "unconsolidating" their cases had ever been issued. Notices of hearings from other consolidated appellants were omitted from the Record, but those hearings are referenced in a letter from Myers' counsel to the hearing officer dated December 9, 2011. But, prior to the hearings that had been scheduled in M.M., C.E. and S.E. for January 3 through 5, 2012, DHHS decided to not impose the caps on those appellants and agreed to continue their services which are in excess of the new limits. R. 523. Chip E. was receiving 52 hours per week of PCA services and Michelle was receiving 56 hours per week of PCA services. *Peter B. v. Buscemi*, Case No. 6:10-767-TMC (D.C.S.C. March 7, 2013). The district judge agreed with DHHS that the claims of Michelle M. and Chip E. were moot and he dismissed them from the case:[5]

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Note that the letter contains a typo identifying the notice regulation as 42 C.F.R. 431.201, instead of 42 C.F.R. 431.210. (At page 600 in Record on Appeal in ALC. To be included in Appendix.).

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~~A final, appealable order has not been issued in that case, because the district judge did not dismiss the claims of the third Medicaid participant. Id.~~ This case is pending in the

> Plaintiffs Chip and Michelle filed an appeal of DHHS's administrative decision to reduce or discontinue certain MR/RD waiver services with the ALC. On November 9, 2011, the ALC filed an order reversing the DHHS's decisions to reduce and or terminate services or supplies to these Plaintiffs. (Dkt. # 169 Defs.' Mem. Supp. Summ. J. Mot. Ex. 2 - ALC's Order of Nov. 9, 2011). The ALC held that the actions taken by the DHHS to reduce or cap Plaintiff's services did not have the force and effect of law because the caps were not promulgated as a regulation. *Id.* at 14. (Emphasis added.)

Id. The district court held in *Peter B.* that: "There is no indication that in the future Defendants will apply the 2010 caps to Plaintiffs Michelle and Chip, especially in light of the ALC's decision."

However, treating Myers differently from Chip E., Michelle M. and Susan E., on December 14, 2011, DHHS informed the Office of Appeals and hearings that Respondent:

> ...intended to impose limit (sic) or 28 weekly hours of Personal Care Aide II services, in accordance with the Waiver limits set in accordance with 42 C.F.R. 440.180(b). The Department also intends to impose a limit of 24 hours of Personal Care Aide I services. These services in addition to the 101 monthly units of Respite care provided are believed to meet the needs of the Petitioner as well or better than services provided under the previous waiver.

R. 523.

Just five days after this letter was sent informing Myers his services would be reduced, after remaining in the family home for more than three decades, he was admitted to a nursing home, on December 19, 2014. R. 657.

At the time of the hearing held at DHHS on January 6, 2012, Myers had been in the nursing home for two and a half weeks. R. 493. He was 34 years old. R. 466. The next youngest patient in that nursing home was 74 years old. R. 493. When Myers was

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United States Court of Appeals for the Fourth Circuit. Michelle M. died before the district court issued a final, appealable order.

institutionalized in 2011, he had been on the waiting list for placement in a community group home for "ten or fifteen years." R. 467.

Myers had twice requested that his "fair hearing" be held in Camden. R. 687 and 691. These requests had not been denied by DHHS. But, on December 19, 2011, the day Myers was admitted to the nursing home, less than one week before Christmas, Mrs. Myers learned that the hearing officer would require the hearing to be held in Columbia. R. 699.

Although not required by Medicaid appeal rules or any order, DHHS filed a prehearing brief in Myer's case December 29, 2011. R. 524.

A hearing was held solely on Myers' appeal on January 6, 2012 (since services in excess of the 2010 caps had been continued for the remaining consolidated case appellants), with a decision issued by the hearing officer on February 9, 2012. R. 20. The hearing officer determined that the reductions and limitations in Medicaid services at issue in Myers' appeal could not legally be treated as "binding norms" or as matters of federal of (sic) state law.[6] R. 27-28. She determined that Myers needed a speech generating device (25), physical therapy to reduce contractures and to maintain range of motion (R. 26), and psychological services (R. 27) in the nursing home. R. 11. The order concluded that Myers would be provided dental services through the State Medicaid Plan. R. 27. The hearing officer held that she could not find a retaliatory motive in the decision

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Yet Respondent continues to enforce these caps as a binding norm that cannot be exceeded. In *B.W. v. DHHS,* the hearing officer ruled that a DHHS hearing officer does not have the authority to exceed the waiver caps. November 19, 2013.

to reduce Myers' services, therefore Respondent had not violated the ADA anti-retaliation prohibition. R. 29. She also concluded that DHHS had not violated *Olmstead* or the integration mandate of the ADA. Id. The order contains a finding that Myers received "adequate notice," without discussing that the specific criteria required by 42 C.F.R. 431.210 was not contained in the "notice." R. 21. There was no discussion in that order as to whether providing the services Myers requested would cause a fundamental alteration in the State's programs or whether the services requested were "specialized services" required by the PASRR regulations. The hearing officer also determined that Myers did not need more than 7 hours a day of "intense services" and that all other needs for supervision and observation could be covered by less expensive Respite services. R. 28. The hearing officer determined that Myers was institutionalized simply due to the "passage of time" and the desires of his caregiver and himself. R. 30.

Myers filed a motion to alter or amend the hearing officer's February 9, 2012 order, which was denied on March 19, 2012. This motion and the March 19, 2012 order of the DHHS hearing officer do not appear to be contained in the Record on Appeal. (The motion is included in the Record on Appeal in this Court at 237.) Appellant filed a notice of appeal to the Administrative Law Court on April 13, 2012. R. 249.

Respondent referred in its brief on Myers' second appeal to the ALC to "the original Record." This "original Record" was not included in the Record submitted to the ALC after remand back to DHHS. Respondent's R. 298. Respondent also argued that Appellant failed to preserve the issue of its defective notice in Appellant's brief that was submitted to the ALC in the first appeal, prior to remand to DHHS:

> This matter was decided in the previous appeal in which this matter was remanded to the Department's Appeals Division. In that decision, the court said that that ground for appeal had not been preserved for appellate review and had been abandoned.

R. 297.

In his brief filed in the ALC on August 2, 2012, Appellant objected to DHHS' failure to include all of the filings and orders in Myer's appeal in the Record filed with the ALC on remand. Appellant's E. 253. ("Documents filed between May 6, 2010 and November 9, 2011, appear to have been omitted by DHHS, and Myers' requests that the Record be supplemented by the hearing officer to include all pleadings and orders in this case." Id.) Appellant's ALC Brief filed in the consolidated case. Respondent refers this to in its brief, which was not included in the Record that is now before this Court, and was not before the Administrative Law Judge when he issued his 2013 order. R. 297.

After briefing, the Administrative Law Court issued an order on February 3, 2014 upholding the decision of the hearing officer, without providing oral arguments. R. 1. Myers' notice of appeal was filed in this Court on March 5, 2014. R. 318.

IV. Argument

Issue 1. Did the agency violate Myers' due process rights and 42 C.F.R. 431.210(b), and did Respondent's notice contain the required "reasons for the intended action" and the statute or regulation that the agency relied upon to support action taken? Is this violation subject to repetition, yet it has evaded review?

The document Respondents claim to meet the notice requirements of the Medicaid Act is a generic notice that informs families that services are being reduced because CMS approved the reductions. R. 632. The "Notice of Termination of Services" provided by

Myers' service coordinator are included on pages R. 661-665. These Notices on or after December 31, 2009 included the following reasons for the State's actions:

Daily Respite	"Daily Respite is no longer covered under the MR/RD waiver. R. 661.
Hourly Respite	Decrease in services, cap in services by DDSN..."Respite Care has been cap to 68 hours per month and personal care has been cap to 28 hours per week." R. 662.
Physical Therapy	"Physical Therapy will no longer be covered under the MR/RD waiver. R. 663.

No other notices are contained in the Record.

The Due Process Clause of the United States Constitution requires Respondent to provide meaningful notice and an opportunity to be heard before an impartial tribunal before government benefits are denied. Id. and U.S. Constitution XIV Amended. *Goldberg v. Kelly*, 397 U.S. 254 (1970). The Constitution of the State of South Carolina provides that:

> No person shall be finally bound by a judicial or quasi-judicial decision of an administrative agency affecting property rights except on due notice and an opportunity to be heard; ... nor shall he be deprived of liberty or property unless by a mode of procedure prescribed by the General Assembly; and he shall have in all such instances the right to judicial review. South Carolina Constitution Article 22.

42 C.F.R. 431.210 provides:

§ 431.210 Content of notice.

1. A notice required under § 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain—

(a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;

(b) The reasons for the intended action;

(c) The specific regulations that support, or the change in Federal or State law that requires, the action;

(d) An explanation of—

(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

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

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

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992]

It is undisputed that Meyers did not receive the notice containing the information required by 42 C.F.R. 431.210. Respondent also violated the due process requirements of the Constitutions of the United States and South Carolina.

In *Kimble v. Solomon*, a federal district court in Maryland ruled the notices of across-the-board reductions in Medicaid services were not "adequate," since they did not state the reasons for the reductions or the circumstances under which a hearing might be obtained and assistance continued.599 F.2d 599 (4th Cir. 1979). The Fourth Circuit ruled in that case that "Where, as here, Maryland failed to comply with the notice regulations, it has not instituted a legally effective reduction in its Medicaid benefits." Id. at 604. This Court should reach the same decision regarding the defective notice provided by Respondent in this case.

In *D.L.B. v. DHHS*, the same DHHS hearing officer that decided Myers' case

ruled in another MR/RD Medicaid appeal decided in August of 2011 that:

> Review of the DDSN Notification of Termination of Services doe find it regretfully lacking in areas of description of reason for action and the specific regulations that support the action. Most egregious is the fact the notice is not sent directly to the person it most impacts, the Petitioner, but to the service provider.

R. 724. Ongoing violations of the notice requirements are found throughout the November 19, 2013 order in *B.W. v. DHHS,* where DHHS repeatedly reduced her services without providing the notices required by 42 C.F.R. 431.210. *Supra.* These violations are capable of repetition, yet they have evaded review.

The Administrative Law Judge erred as a matter of law and demonstrated prejudice in basing her decision that Appellant's notice issue was not preserved for appeal in the brief Appellant filed in the Administrative Law Court in the consolidated case. This ruling violates Myers' due process rights, because the Appellant's Brief in the consolidated appeal, which the Administrative Law Judge claims to have relied upon, was not in the Record before her and the judge had ignored Appellant's request to supplement the Record to include that brief and other documents DHHS had selectively omitted. R. 253 and 314. By failing to include this brief in the Record, Appellant is unable to challenge the factual error committed by the hearing officer and the lower court in reaching this decision. Certainly it was a violation of Appellant's due process rights and legal error to refuse to supplement the Record with the very document that the judge intended to rely upon in ruling against Myers on this issue. In Medicaid appeals, DHHS has the sole responsibility and power to prepare the Record and, as demonstrated in this case, an Appellant may be prejudiced by its decision to omit documents filed by the

appellant.

In any event, federal regulations require that the hearing officer's decision must be based "exclusively on evidence introduced at the hearing." 42 C.F.R. 431.244(a). The hearing officer was prohibited by this regulation alone from basing her decision on any evidence not presented at the hearing. It was legal error for the hearing officer or the ALC to rule against Myers on this issue based on evidence that was presented prior to remand and the "fair hearing." Without giving a bit of consideration to the clear and unambiguous requirements for content of notice in 42 C.F.R. 431.210. In addition, this ruling plainly ignores the fact that Respondent's own witnesses admitted that the "notice" provided to Myers did not meet those federal requirements. Therefore, the hearing officer concluded, without any evidentiary support, that "Petitioner has had adequate notice of the intended reductions and the issues." R. 29.

As the South Carolina Supreme Court held in *Doe v. DHHS:*

> In accordance with our statutory law, we hold an agency guideline does not have the force of law, and in any event, can never trump a regulation. Our law provides that " ' [r]egulation' means each agency statement of general public applicability that implements or prescribes law or policy or practice requirements of any agency. *Policy or guidance issued by an agency other than in a regulation does not have the force or effect of law.* " S.C. Code Ann. § 1-23-10(4) (2005) (emphasis added).

98 S.C. 62, fn 7, 727 S.E.2d 605 (S.C. 2011). The agency's practice of providing "complimentary notices" containing reasons different from those argued at the "fair hearings" cannot trump federal regulation requiring the agency to follow all federal regulations interpreting the Medicaid Act in return for matching federal funds. Medicaid is an optional program, in which States may elect to participate. *Doe v. Kidd I,* 501 F.3d

348, 351. (4th Cir. 2007). However, as the Fourth Circuit recognized in that case: "Once a state elects to participate in the program, it must comply with all federal Medicaid laws and regulations." Id.

The DHHS official in charge of the MR/RD Medicaid waiver program, Kara Lewis, testified at Myers' hearing that the notice provided to him was simply a "courtesy announcement.[7] R. 407. Moreover, it is uncontradicted that this "notice" did not contain the information required by 42 C.F.R. 431.210. Id.. Lewis admitted at the hearing that DHHS' notices are required to include the reason for the action, but the hearing officer and the ALC ignored this admission of violation of federal law. Id. Ms. Lewis admitted at the hearing that the December 1, 2009 letter does not contain any reference to the law or regulations upon which the changes were based. R. Id. She admitted Respondent's obligation to include the legal basis for the decision in the notice:

> Q. "Do they also have to include the regulation or the law?
> A. "I would agree with you that they probably are supposed to include the law.
> Q. "Is that a requirement?"
> A. "I think it probably is."

Id. This legal error is subject to repetition, yet it evades review. The agency has not corrected its illegal practices after Myers called this violation to their attention. The hearing officer in this case, Betsy Schindler, found in another case involving DDSN termination of a waiver service that the agency's notice of termination was defective and in violation of 42 C.F.R. 431.210. *D.L.B. v. DHHS*, Appeals Case #11-MISC-156

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7 Kara Lewis holds a BS with a "major in Health Care" from Appalachian State. R. 404. She has no graduate or medical training.

(MR/RD Waiver) dated August 15, 2011.

An important component of the notice regulation is that the State must provide the appellant with the reasons for the reductions. Without this information, it is impossible for a Medicaid participant to know what evidence he needs to produce at the hearing and what witnesses he should bring. The only "reason" provided in the "notice" contained on page 632 was that "The Centers for Medicare and Medicaid (CMS) has approved the changes to the MR/RD Waiver. The Notice of Termination of Services provided by Myers' service coordinator are congruent with this "reason." The legitimacy (or illigitimacy) of relying upon CMS approval, notwithstanding the requirements of the ADA and the Medicaid Act, should have been the sole reason upon which the State was allowed to rely at the hearing.

Federal courts in the Fourth Circuit and other places have knocked down that justification for terminating or reducing services and prevented States from implementing reductions that had been approved by CMS. *Peter B. v. Sanford,* Case No. 6:10-cv-00767 (D.C.S.C. March 7, 2011).; *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013); *Moore v. Cook,No.* 1:07-CV-631-TWT, 2012 WL 1380220, at *10 (N.D. *Ga*. June 19, 2012); *Royal v. Cook*, Case No. 1:08-cv-2930-TWT (N.D.Ga. June 19, 2012); and *Crabtree v. Goetz*, 2008 WL 5330506, at *25 (M.D. Tenn. Dec. 19, 2008). Congress did not give employees at the regional offices of CMS - or Administrative Law Courts - that authority to override their clear intentions.

The hearing officer correctly held that Myers had prevailed on his arguments contained in the consolidated brief that the waiver reductions were unenforceable binding

norms. That was the only grounds the State should have been allowed to argue at his "fair hearing," because no other "reason" was provided in the admittedly defective notice.

Because at the hearing, Respondent offered a new and unusual "reason" for the reductions in services, even a person with a vivid imagination could not have foreseen. Respondent's witnesses testified that "supervision" had been removed from the definition of PCA services and that "most people could not tolerate being bathed, groomed, dressed, fed for that many consecutive hours." R. 329. There was no indication from the notice provided to Myers that this grounds was used in reaching the decision to reduce and terminate his services. Janet Brock Priest testified that the reductions were made because "something was needed to be done to clarify what was meant by personal care," so Respondent changed the definition of that service. This "reason" was not provided to Myers or any waiver participant. Myers had no notice that the medical necessity for his services would be challenged at the hearing and he had not been given any notice, written or otherwise, of those grounds.

If he had been notified that Respondent intended to challenge the medical necessity of his home-based services, he could have provided live testimony from his treating physicians and his dentist. He was not on notice that Respondent would argue that a DDSN service coordinator has the authority under DDSN Medicaid programs to override the opinion of a treating physician. R. 342. Myers could have requested that a member of the South Carolina Board of Medical Examiners to testify as to what constitutes the practice of medicine had he known that the Respondent was going to base its defense on the authority of a DDSN service coordinator to override the orders of a

treating physician.

The lower court erred in its finding that Myers was not prejudiced by the failure to inform him of the regulations and the reasons Respondent would rely upon at the hearing to defend its adverse action. Plain and simply, Myers lost because Respondent relied upon totally different reasons to support its decision at the hearing - reasons he could not have imagined, based on the "notice" that was provided. The hearing officer and the Administrative Law Judge exceeded their authority and acted arbitrarily and capriciously by ignoring the federal regulations that required DHHS to provide Myers with notice containing the reasons for the adverse action, as well as the statutes or regulations it relied upon. These violations are ongoing and they will continue until the Judicial Branch orders Respondent to comply with the law, and puts some teeth into that order to prevent other disabled persons from suffering the fate Myers is now experiencing as a result of the reductions in his services. This is a matter of extreme public importance.

Issue 2. Are the reductions and terminations of Medicaid services Myers complained of in this appeal unenforceable because they were not promulgated as regulations pursuant to the South Carolina Administrative Procedures Act?

In *Hickey v. DHHS,* the ALC found that:

> ...the general language allowing the Department to promulgate regulations does not override the more specific requirements of the APA. Such an interpretation does not yield a reasonable and practical construction consistent with the purpose and policy expressed in either the APA or § 44-6-90. Therefore, the Department erred in treating the cap on PCA II services as a binding an enforceable rule without promulgating the cap as a regulations pursuant to the APA.

Dkt. No. 10-ALJ08-0656-AP, (SCALC July 19, 2011). R. 707. These caps were

determined by the ALC in that case, because they establish a binding norm without promulgation of regulations. In overturning Respondent's decision in another case that was based on a DDSN policy that was enforced for years by the agency without promulgation as a regulation, the South Carolina Supreme Court recently warned Respondent:

> In accordance with our statutory law, we hold an agency guideline does not have the force and effect of law, and in any event, can never trump a regulation. Our law provides that "[r]egulation means each agency statement of general public applicability that implements or prescribes law or policy or practice requirements of any agency. *Policy or guidance issued by an agency other than in a regulation does not have the force or effect of law.* S.C. Code Ann. §1-23-10(4) (2005) (emphasis added). Thus because the age-eighteen-onset requirement found in DDSN's policy guidelines has not been formally adopted as a regulation, it does not have the force and effect of law and is entitled to no deference.

Jane Doe v. DHHS, South Carolina Supreme Court, December 28, 2011.

While the hearing officer gave lip service to Respondent's argument that the reason contained on the "notice," i.e. establishment of caps on services, was not the basis for the reductions in Myers' services. The letter of Director Beverly Buscemi reveals the real reason for reducing Myers' services:

> These approved limits cannot be exceeded and must be applied to al MR/RD Medicaid Waiver participants...While we understand and appreciate the hardship these changes may place on your family, we are not at liberty to exceed the established limits.

R. 686. When asked who can decide to exceed the limits, the DDSN official responsible for the operation of the waiver, Janet Priest, responded that: "It's my understanding that no one does." R. 339. Priest is responsible for DDSN's operation of the MR/RD

Medicaid waiver and she testified that DDSN and DHHS have not even discussed promulgating regulations. R. 343. Ms. Priest confirmed that no one can receive more than 28 hours of personal care services:

> Q. Okay, so who can decide to exceed the twenty-eight hours a week personal care attendant? Who has the authority to do that?
> A. It's my understanding that no one does.

R. 339.

Myers' DDSN service coordinator, Juanita Auker, confirmed that the reason Myers' services were reduced was because of the imposition of caps on waiver services. R. 371 and 380. She was not aware of any regulations for the operation of the MR/RD Medicaid waiver program and she testified that she relies on the DDSN manual instead to make service determinations.[8] R. 382 and 383. When asked if she was aware of any regulations promulgated by the General Assembly for the operation of the waiver program, Auker responded "No." R. 383.

The DHHS official responsible for the administration of the MR/RD Medicaid waiver program, Kara Lewis, testified that service coordinators must rely upon the MR Policy Manual written by staff at DDSN to determine what Medicaid services will be authorized. R. 418 and 419. Lewis testified that she had discussed the promulgation of regulations only with "our Legal team," but admitted that "We didn't have any ideas." R. 419-420. The Record contains the following exchange with Ms. Lewis about

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8 Auker holds a Bachelor's degree in psychology and a Master's in counseling, but she is not a licensed counselor. R. 370. The Record contains no evidence that she has any medical training.

promulgating regulations:

Q. But you haven't done anything to promulgate regulations?

A. I have not.

Q. Okay, do you think that's necessary?

A. I don't know enough about it to give you an intelligent answer to tell you the truth.

Q. Okay. Have you talked about promulgating regulations with anybody at DDSN?

A. I haven't.

Q. Okay. So you haven't talked to anybody over there about whether or not they should promulgate regulations or you should promulgate regulations they'd have to comply with?

A. I haven't.

R. 420.

It is clear from the evidence presented in this case that Myers' services were reduced because of the caps on services, not based on his lack of need for the services. The hearing officer and the ALJ acted arbitrarily in upholding the agency's reduction of Myers' services under the guise of the amended waiver program meeting his medical needs. Myers requests that this Court issue an order stating that the caps are unenforceable and that the totality of the Record demonstrates that the improper imposition of these caps was the true and unenforceable reason for reducing Myers' services.

Issue 3. Did the agency err in its determination that the services ordered by Myers' physician were not medically necessary because Respondent failed to provide any evidence from a qualified source that contradicted the orders of Myers' physician and the evidence from other qualified sources presented at the hearing?

In *Olmstead v. L.C.*, Justice Kennedy, in his concurring opinion, opined that: "The

opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference."527 U.S. 581, 561 (1999). According to Priest, the opinion of a waiver participant's treating physician is weighed by the DDSN service coordinator, who she claims has sole authority to approve or disapprove services: "like any information that we get from a teacher, from a parent, from a familiar caregiver." R. 351. When asked how service coordinators are trained to weigh the opinion of a waiver participant's treating physician, she testified: "We don't tell them to weight it more heavily. We don't tell them to discount it. We tell them to consider it." Id. Lewis testified that "We - we don't necessarily use medical criteria" for determining medical necessity. R. 416-417. According to Lewis: "This Waiver is not based on medical necessity." R. 417. She reported that service coordinators make treatment decisions by giving "equal weight to all of the information they would gather" to obtain a "holistic picture." R. 417. She was not aware of regulations concerning medical necessity. Id. That was because DHHS does not base this waiver as a "medical model." R. 418. She testified that the service coordinator talks with the family and puts the information "in a basket so to say" then proposes a plan and meets with her supervisor or the Executive Director of the local DSN Board. R. 418. She "supposed" that the Executive Director could override the service coordinator. R. 418 and 419.

The importance Congress intended to place on the opinion of the treating physician and other health care professionals in determining what treatment is medically necessary is obvious from the legislative history of the Medicaid Act:

The committee's bill provides that the physician is to be the key figure in

> determining utilization of health services - and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the bill would require that payment could be made only if a physician certifies to the medical necessity of the services furnished.

S.Rep. No. 404, 89th Cong., 1St Sess., reprinted in 1965 U.S.C.C.A.N. 1943. Relying upon this legislative history, numerous courts have emphasized that State procedures that interfere with a treating physician's professional judgment concerning medically necessary treatment violate the Medicaid Act. *Pinneke v Preisser*, 623 F.2d 546 (8th Cir. 1980)."[T]he decision of whether or not certain treatment or a particular type of surgery is 'medically necessary' rests with the individual recipient's physician and not with clerical personnel or governmental officials." Id. at 550. In *Beal v Doe,* the Supreme Court emphasized the importance of professional medical judgment in making treatment decisions. 432 U.S. 438 (1977). "[T]he decision whether to fund the costs of abortion thus depends solely on the physician's determination of medical necessity."

Furthermore, the South Carolina Board of Medical Examiners has determined that:

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

See http://www.llronline.com/pol/medical/index.asp?file=Policies/MedNecessity.htm.

The Medicaid Act requires that States establish "reasonable standards" for determining how services are delivered. Pursuant to 42 U.S.C. § 1396a(a)(17), a state plan for medical assistance "must . . . include reasonable standards (which shall be comparable for all groups . . .) for determining eligibility for and the extent of medical assistance under the plan."

Federal law does not define the term "medically necessary, " but the Medicaid Act grants participating states the authority to promulgate "reasonable standards" for determining whether and to what extent requested services are medically necessary. As the Fifth Circuit held in Hope Med. Grp. for *Women v. Edwards:*

> Title XIX "confers broad discretion on the states to adopt standards for determining the extent of medical assistance" provided through their Medicaid programs. Beal v. Doe, 432 U.S. 438, 444, 97 S.Ct. 2366, 2371, 53 L.Ed.2d 464 (1977). However, states' discretion to limit the scope of the medical services offered through their Medicaid programs is subject to important restrictions. Title XIX specifically provides that participating states must establish "reasonable standards" that are "consistent with the objectives" of the Act. 42 U.S.C. Sec. 1396a(a)(17). Some courts have read this provision as mandating that states must cover all medical procedures certified as "medically necessary" by a recipient's physician. See Weaver v. Reagen, 886 F.2d 194 (8th Cir.1989); Pinneke v. Preisser, 623 F.2d 546, 548 n. 2 (8th Cir.1980).

63 F.3d 418, 425 (5th Cir. 1995). That case cites 42 U.S.C. § 1396a(a)(17), as requiring the state plan to "include reasonable standards... for determining... the extent of medical assistance under the plan which are consistent with the objectives of [the Medicaid Act]"). 42 C.F.R. § 440.230(d) permits the state Medicaid agency to "place appropriate limits on a service based on such criteria as medical necessity". However, the state's standards must nevertheless be "consistent with the Act's objective of providing a broad

range of health-sustaining services." Hope Med. Grp., 63 F.3d at 427-28.

For many reasons, the State is certainly not at the mercy of any physician who irresponsibly prescribes unnecessary treatment. When a State disagrees with the treating physician about whether a service is medically necessary, due process requires that a fair hearing be provided. 42 C.F.R. 431.200 et. seq. In *Moore v. Reese*, the Eleventh Circuit determined that a state may adopt a definition of medical necessity that places limits on the treating physician's discretion. 637 F.3d 1220 (11th Cir. 2011). The state may also establish standards that individual physicians must use in determining what services are appropriate in a particular case and require treating physicians to operate within such reasonable limitations as the State may impose. Id. But Respondent has utterly failed to promulgate regulations to establish such limitations or a definition of medical necessity. In fact, Respondent has repeatedly ignored court orders finding that it must promulgate regulations before establishing binding norms such as the ones at issue in this case.

Undeniably, the State has a role to play in determining medical necessity, but reasonableness requires that the State's representative making the determination of medical necessity be qualified under the State's law to prescribe medical treatments. Respondent failed to present any opinion - or even a scintilla of evidence - from any qualified medical source to contradict the opinion of Myers' treating physician and physical therapist. According to the DDSN official who is responsible for the agency's operation of the MR/RD waiver program, only the service coordinator can authorize services. R. 350.

Priest testified about a service coordinator going to a home and determining that

"it was obvious that nobody understood the person." R. 339 to 342. She testified that at some point "the physician *could* be involved...," but that the service coordinator had the power to "override" the physician's determination. R. 342. According to Priest, the service coordinator is not "bound to comply with doctor's orders..." and that "There's no written criteria for that." R. 348. Priest testified that "We don't determine medical necessity." R. 349. She reported that "...the service coordinator is the one who assesses needs." Id. She said that "The service coordinator does an assessment of the need - does an assessment to determine what needs the person has and then develops a plan or authorizes services to meets (sic) those needs." R. 350. When asked if this practice complies with federal law, Priest responded again: "As I understand Waiver services, the service coordinator authorizes the services based on the assessment." Id. She did not know whether the federal government requires that services be medically necessary before Medicaid will pay for them. Id. Allowing a case manager to authorize or deny services clearly and undeniably contradicts federal regulations found at 42 C.F.R. 441.18(a)(6) which prohibit case managers from "exercising the authority to authorize or deny the provision of other services under the plan." These regulations instruct States not to allow case managers to "restrict an individual's access to other services under the plan." 42 C.F.R. 441.18(a)(2).

Thus, Respondent's decision to deny the services Myers' physician ordered was not reasonable. In the event that the treating physician is not making a reasonable determination of medical necessity, the State's remedy is to present testimony from a medical practitioner with qualifications in the medical field at issue. But Respondent did

not present a single iota of medical evidence to dispute the treatment decisions of Myers' treating physician, Dr. Munn. The hearing officer may even require the participant to submit to a medical assessment by an independent examiner when the examining physician's opinion is questioned by the State. 42 C.F.R. 431.240(b). However, what the State may not do is to base its decision upon a determination made by a person with no medical qualifications, as was the case in Myers' appeal. Such a determination would not be reasonable, based on federal case law, the Congressional intent shown in the legislative history of the Medicaid Act and the policies of the South Carolina Board of Medical Examiners. As recognized in *Rush v. Parham,* 440 F.Supp. 383, 389-90 (N.D.Ga.1977), a treating physician's treatment decisions are "governed by the standards and ethics of his profession and by the dictates of federal and state law." *Id.* ; *see also id.* at 390 n. 12 (citing statutory criminal penalties for knowing or wilful misrepresentations in a Medicaid benefits application).

The Record contains credible and reliable evidence from Myers treating physician, Dr. Munn, supporting his opinion that Myers requires constant around-the-clock supervision. R. 611 and 614. She determined that "with the necessary supports," Myers would be able to live in the community, and that the services he received before admission to the nursing home were "woefully inadequate." R. 617. Witness Sandra Ray testified that Myers would be able to live in the community if the services ordered by Dr. Munn had been provided.[9] R. 433. Dr. Munn determined that in order to live in the

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The guardian ad litem appointed by the Probate Court in Myers' guardianship proceedings, Sandra Ray, holds a Master's Degree in Speech Pathology, a law degree, a

community, Myers required eight hours a day of nursing services on the days he was not attending a day program, due to his need to be fed through a feeding tube three times a day and to administer medications through this tube in the evenings. R. 611. She opined that "He is at a high risk for infection and rapid decline in his health if these services are not provided." Id. In addition to PCA services, Dr. Munn prescribed physical therapy and occupational therapy to prevent regression and to prevent contractures which would require surgical intervention. Id. Speech services were also prescribed by Dr. Munn. Id. She determined that Myers needed a speech device that would allow him to communication by moving his eyes, since he is unable to use his hands or feet and a device that requires manual dexterity "would be of no use to Mr. Myers." R. 616. The need for this device increased upon entry to the nursing home, according to Dr. Munn. R. 615.

Ms. Ray explained why Myers needs a speech device that would allow him to use eye gaze to control the device. R. 423 to 425. According to Ray, this device would allow Myers to avoid hospitalization and described how being able to communicate would prevent skin break down that may result in dangerous decubitus ulcers. R. 435. Lennie Mullis agreed that a speech device was medically necessary. R. 439 to 440.

Dr. Munn also prescribed a motorized wheelchair which would allow Myers to change positions which conforms to his body "in order to prevent gastrointestinal and

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Master's in Educational Leadership and holds a degree as an Educational Specialist. She has worked with people who have disabilities like Myers for more than twenty-five years. R. 421 to 422. She worked for a national organization providing risk management for this population. Id.

pulmonary problems which would likely lead to hospitalization." R. 616..

Dr. Munn determined that the failure to provide these services resulted in Myers be placed in a nursing home. R. 614 to 617.. She affirmed that:"If these services and supports that were ordered had been provided, including the number of hours of nursing and personal care attendant services determined to be medically necessary, it is likely that Mr. Myers would have been able to remain in the community in a less restrictive setting." R. 614. Ms. Mullis agreed that if the services Dr. Munn had ordered had been provided, Myers would likely have remained in the community and that his mother needed "many more hours" than DDSN authorized. R. 449 and 450.

Dr. Munn determined that respite services are not an "acceptable alternative" to nursing and personal care services, because the rate of pay "does not attract the type of employee who has the capability to provide the supervision Mr. Myers needs." R. 614. Lennie Mullis testified about the "horrific shortage" of respite providers. R. 448 to 449. According to Mullis: "there are very few respite providers because the reimbursement rate is so low that agencies, provider agencies do not want to take that on." Id. She also testified about the risk DDSN requires families to assume when they hire respite workers. R. 447.

She expressed a medical need to received specialized services to allow Myers to communicate and his need for adult companion services. R. 440, 444 and 451. Dr. Munn determined that psychological services were needed twice each month "or more frequently if it appears that his condition is worsening." R. 615. This need for psychological services was confirmed by Myers' GAL, Sandra Ray. R. 431 to 432. Dr.

Munn prescribed physical therapy for "at least one hour each week, or as determined to be medically necessary by a qualified physical therapist." R. 615. Dr. Munn agreed with the assessment performed by Myers' physical therapist, Darilyn Galloway-Coke. R 878 to 879. According to Dr. Munn, these physical therapy services were necessary to "prevent costly hospitalization which is likely to occur not only from contracture of his muscles, but from gastrointestinal and pulmonary disorders which are likely to result from worsening of his condition of scoliosis." R. 615. Witness Lennie Mullis testified that Myers' physical condition has deteriorated over the last years and his scoliosis has "rapidly increased" for lack of therapy. [10] R. 438. She described the risk of gastrointestinal blockage and pneumonia if the services ordered by Dr. Munn are not provided. R. 439.

Dr. Munn ordered vision services to be provided through an annual eye exam. R. 615. She opined that Myers needs to be put to sleep for dental services to be performed and that Myers risks infection which would lead to hospitalization if dental services are not provided. Id. According to Dr. Myers: "Poor oral status significantly increases the risk of developing respiratory infections, including pneumonia, in persons with developmental disabilities." R. 616. The risks of failing to provide dental services at least twice a year were discussed by Lennie Mullis. R. 442. She testified that "If you have a (sic) abscess or you have strep or if just have diseased gums, a gum disease, your whole body suffers

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Ms. Mullis has 30 years experience working with persons with disabilities like Myers'. She is a provider of DDSN behavior supports and psychological counseling services. R. 437. Mullis served as the director of a local DSN Board for seven years.

from that..." Id.

Nothing in the records presented to the hearing officer by DDSN service coordinator Auker contradicts these medical opinions. Indeed, these medical records document the development of pressure sores that were not healing and an injury to Myers right arm, a clear worsening of his condition after his primary non-familial caregiver was injured and was no longer providing care to Myers. R. 669. In one of Auker's last entries, Auker also noted that Myers' scoliosis had increased. R. 684. Yet Auker testified that Myers' request for nursing and additional PCA hours was denied because his condition had not changed. R. 386. Aukers' testimony is not credible. She admitted having no medical training at all. R. 385. Auker was paid by DDSN to provide "targeted case management," a service described in 42 C.F.R. 440.169. As such, she was charged with assisting Myers with obtaining services. Instead, Auker's records document that she was simply asking his already overloaded mother to do the job of a service coordinator and to locate and arrange for needed services. There is no indication in these records that Auker took any actions to schedule appointments to help him obtain needed physical therapy, dental or speech services (42 C.F.R. 440.169(d)(3). Auker was paid by Medicaid to help "link the individual with medical, social, and educational providers or other programs and services that are capable to providing needed services to address identified needs and achieve goals specified in the care plan. Id. She failed to assure that Myers' plan was "effectively implemented" and that it adequately addressed his needs. Indeed, Auker repeatedly informed Myers' guardian that the additional personal care services could not be provided, based on the caps. Her notes state that "they could not request more PCA II

hours because Albert is already receiving over the cap amount due to the appeal." R. 672 and 678. On July 14, 2011, Auker wrote in her notes that: "After checking into the process and situation with Albert's (c) appeal SC discovered that Albert can not request any more PCA II hours due to him already being over the cap...no more units can be approved because he is already over the cap. R. 678.

Again on July 29, 2011, Auker wrote: "SC emailed Dawn Shealy, District I Program Manager to let her know SC was mailing information. She informed SC that no more hours could be approved until appeal was over. R. 679. On August 10, 2011, Auker wrote that: "SC informed her that no more hours could be approved due to Albert going through the appeal." R. 680. Auker documented Myers' request for nursing hours, but those were never provided. R. 680. Auker informed Myers' guardian that nursing services cannot be provided on the same day that he receives five Adult Day Health Care services, another binding norm not promulgated as a regulation. R. 681.

According to Lewis and Priest, the DDSN service coordinator has the sole authority to determine what services will be provided to a Medicaid waiver participant. Auker documented discussion about Myers need for a communications device on September 2, 2011, but this device still has not been provided to Myers, in clear violation of the reasonable promptness standard of the Medicaid Act. R. at 874 and *Doe v. Kidd II,* 419 F. App'x 411 (4th Cir. *2011*). In her testimony, Auker stated that she never authorized the speech device that Dr. Munn determined that Myers needed. R. 379. She testified that she did not know what the restrictions were for Myers to obtain speech therapy. Id. Auker admitted that she never authorized the nursing services ordered by Dr. Munn. R. 383-390.

When asked how she determined medical necessity, Auker testified that "I don't necessarily determine medical need. We go by our assessment and assess the needs that are there." R. 385. She never spoke with Myers' physician, but just denied the hours he ordered. R. 385. She "didn't give deference to anything," but claimed to have made her treatment decisions by looking "at the whole picture. R. 387 and 388. When asked again what weight the orders of Myers' physician carried, Auker testified that "I wouldn't say that anything carried more weight than the other. R. 399.

Auker testified that Myers continues to need physical therapy, psychological services and socialization, but she terminated his authorization to receive psychological services. R. 390 and 393, 663, 684.

DDSN did not consult Auker, Myers' physician, his mother nor his GAL before deciding that he has no need for "specialized services" in performing the Level II PASRR evaluation. R. 392, 393.

Medicaid services must also be provided with "reasonable promptness" pursuant to 42 U.S.C. 1396a(a)(8). Lewis testified that the "reasonable promptness" provision of the Medicaid Act required that services be provided within 45 or 90 days. R. 415, 416. Aukers' records document that she did not assist Myers' guardian in obtaining needed services. She simply noted in her records whether or not Myers' guardian had been able to independently obtain these services. It is obvious from the service coordination records that she acted simply as a gate keeper, which is prohibited by federal regulations. 42 C.F.R. 441.18 (a)(6) prohibits "providers of case management services from exercising the agency's authority to authorize or deny the provision of other services under the

plan." The Fourth Circuit has upheld a South Carolina MR/RD Waiver participants right to receive services with reasonable promptness. *Doe v. Kidd I,* 501 F.3d 348 (4th Cir. 2007) and *Doe v. Kidd II,* 419 F.Appx. 411 (4th Cir. 2011).

The standard established by Respondent is patently unreasonable. All of Respondent's witnesses testified that the agency's policy is for the decision to authorize or deny medical services is made by the DDSN service coordinator, who has no medical training and her notes confirm that she was being instructed to deny Myers' service requests based on the caps established on January 1, 2010.

The only witness from DDSN state offices repeatedly admitted that she knew nothing about Albert Meyers: "I don't know anything about Mr. Myers' situation." R. 340, 348, 353, 354 and 365. One year after Myers filed his appeal, Priest did not know whether he was able to walk, talk, bathe himself, prepare his own food or eat. R. 354.

The hearing officer and the lower court erred in their determination that the services ordered by Myers' physician were not medically necessary because Respondent failed to provide any evidence from a qualified source that contradicted the orders of Myers' physician and the evidence from other qualified sources presented at the hearing. When this Court considers the Record as a whole, it should reach the same conclusion reached by the district court in *Moore v. Cook*, that the decision to reduce Myers services was based on "bureaucratic gobbledegook having no relation to her (in Myer's case "his") actual condition or need." *Moore v. Cook*, Civil Action File 1:07-CV-631 (N.D.Ga. April 19, 2012). The decision of the lower court is not supported by any credible or reliable evidence, it is arbitrary and capricious and that decision should be reversed.

Issue 4. Did the hearing officer and the lower court err in its finding that Respondent did not retaliate against Myers and his guardian in violation of the anti-retaliation provisions of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act and the Civil Rights Act?

As the United States Court of Appeals for the First Circuit held in *Weber v. Cranston* School Committee:

> It is a practical reality that recipients of federal funds sometimes respond to complaints about their treatment of a disabled child by retaliating against the disabled child, the initiator of the complaint (who is often a parent), or both.

212 F.3d 41, 49 (1st Cir. 2000).

Myer's mother spoke publically against the reductions in services Respondent was planning at the meeting where families first learned of Respondent's plan to amend the MR/RD Medicaid waiver. R. 478. At the end of that meeting, she collected a list of persons in attendance and created a mailing list. She used that list to inform families about Respondent's scheme to cut Medicaid services. R. 479. At the time of the "fair hearing," in early 2012, Appellant was sending out information to 600 parents. R. 480. She had been attending DDSN Commission meetings and disseminating information from those meetings to people across the state. R. 480-481. She was in touch with other families on a daily basis on advocacy issues. R. 481. According to Mrs. Myers' testimony, Respondent had been planning the reductions for a year and a half, but families were not informed about the plan until it was a "done deal." Id. Mrs. Myers was involved in establishing an advocacy group called "South Carolina Voices for the Voiceless" and she served as the second president for that group. March 19, 2015. 481.

Myers' service coordinator informed Mrs. Myers that any parent who appealed the reductions would be required to repay DHHS for the services provided to their child during the appeal. R. 482. She learned that other parents were being given the same false information. Id. She notified parents across the state that they should appeal and that the State could not hold them personally liable for the cost of the services provided to their adult children. She testified that she told parents: "Or if you feel like you're being threatened and it will hurt you, you can appeal but you do not have to pay that money back." R. 482. Based on her personal experience communicating with families across the State, Mrs. Myers testified that "People are very scared of retaliation. It's a very real fear among parents." R. 482. She testified that other parents called her to warn her that "you really shouldn't be doing this." R. 483.

Mrs. Myers testified that she "stood up at the end of the meeting and asked a question as you see, I figured they can't fire me. So I stood up at the end of the meeting and I asked a question ..." R. 487. She testified that she believed that her son experienced retaliation because DHHS continued the services of the other three Medicaid participants in the consolidated case, while imposing the cuts against her son.[11] R. 488.

Lennie Mullis is provider of psychological services to Medicaid participants around the State. R. 437-438. When asked about retaliation, she testified that:

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Mrs. Myers testified that before the reductions, her son was provided respite services at home costing $70 a day. R. 489. But, after the reductions, DHHS paid $270 a day for respite services in an institution and "somebody was making money off of that." R. 490. Her requests for nursing services at home were denied. R. 492. She was informed that Myers' PCA hours would be reduced to 28 hours a week and there was "always that threat hanging over us that might lose those hours." R. 491.

> People are very anxious, very, very anxious that if they complain too much they will lose the services that they have. That is an overall concern of families.

R. 450. She testified that one vocal parent's respite services were reduced after she complained and reductions in services were "very arbitrary and capricious, no rhyme or reason how things are done." R. 444.

Ms. Mullis had experienced the arbitrary and capricious practices of DDSN and DHHS firsthand. Twice DHHS terminated her certification as a provider, and twice the Administrative Law Court determined that these actions violated her due process rights and that the agency action was arbitrary and capricious. *Mullis v. DHHS II,* 10-ALJ-08-0775 (S.C.A.L.C. April 23, 2012) and *Mullis v. DHHS I* (S.C.A.L.C. 2005). In *Mullis v. DHHS II,* the South Carolina Administrative Law Court affirmed that improper *ex parte* communications occurred in another fair hearing. In that case, the hearing officer emailed Kathi Lacy, the Associate Director of DDSN, asking "I need your input on this." Dr. Lacy responded: "I believe [the appellant] wants to bring up a previous appeal, likely 6 years ago. ...It has nothing to do with the current issue." Id. But both the Administrative Law Court in former appeal and the appeal decided in 2012 held that Respondent had arbitrarily violated Mullis' due process rights by terminating her contract to provide services to DDSN consumers. Id. Similar *ex parte* communications occurred in Myers' appeal, when one of Dr. Lacy's staff members sent memos to the Office of Hearings and Appeals outlining the agency's position on the appeal, without providing a copy of Myers' counsel. R. 688. One of these memos was sent to the Office of Hearings and Appeals the day before the hearing officer dismissed Myers' appeal without providing

him with a hearing that is required by federal law. R. 689.

Title II of the Americans with Disabilities Act provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. The anti-retaliation provision contained in Title V provides that " [n]o private or public entity shall discriminate against any individual who has opposed any act or practice made unlawful by this part or because such individual made a charge, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under this chapter." § 12203(a).

Section 504(a) of the Rehabilitation Act states that:

> No otherwise qualified individual with a disability in the United States ... shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance....

29 U.S.C. § 794(a) (*codifying* Section 504). Section 504 of the Rehabilitation Act incorporates the anti-retaliation provision of Title VI of the Civil Rights Act of 1964:

> The remedies, procedures, and rights set forth in title VI of the Civil Rights Act of 1964 ... shall be available to *any person aggrieved by* any act or failure to act by any recipient of Federal assistance....

29 U.S.C. § 794a(2) (emphasis added).

The anti-retaliation provision of Title VI of the Civil Rights Act has been incorporated by the Rehabilitation Act to extend that Act's protection to:

> ...any individual' who has been intimidated, threatened, coerced, or discriminated against 'for the purpose of interfering with [protected rights]' under Title VI of the Civil Rights Act or the Rehabilitation Act.

Weber v. Cranston School Committee, 212 F.3d 41, 48 (1st Cir. 2000) (*quoting* 34 C.F.R. § 100.7(e)); (*citing* § 104.61) (granting standing under section 504 of the Rehabilitation Act to a mother who claimed the school system had retaliated against her personally for attempting to enforce her disabled child's rights). See also *Barker v. Riverside County Office of Education,* 584 F.3d 821 (9th Cir. 2009).

The lower court erred in its conclusion that Myers failed to present any evidence of actual retaliation specific to Appellant. Quite on the contrary, not only did Respondent continue the services of the other three Medicaid participants in the case consolidated with Myers' case, but DHHS has exceeded the caps in other cases as well. *Hickey v. DHHS, supra*; *K.E. v. DHHS,* Case No. 10-ALJ-03-0353-AP (S.C.2010).

Mrs. Myers testified that her requests for nursing services were denied, despite being ordered by Myers' treating physician. R. 491 to 492. Myers was awarded less than one-half the number of respite hours that were allowed, even under the reduced caps.[12] R. 371. Myers' dental, psychological and PT services, which were provided prior to entry to the nursing home, were discontinued in violation of the agency's policy to continue services during an appeal. Pursuant to the agency's policies, services are continued during an appeal, but Myers' services were not.

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The assessment performed by Respondent's agent found that Myers only needed 101 hours of respite R. 371 and R. 331 to 332.

Myers complained at the hearing that, regardless of his admission to the nursing home, DHHS continued to be obligated to provide these services due to the Pre-admission Screening and Resident Review (PASRR) requirements contained in the Medicaid Act at 42 U.S.C. 1396ra(3)(F), which begin at 595 of the Record in this case. Those federal regulations required Respondent to provide "specialized services," *even after he was admitted to the nursing home, regardless of the status of his appeal.*

In 1987 Congress amended Medicaid by enacting the Nursing Home Reform Act, because many states were reducing crowding at state institutions by transferring mentally disabled people to geriatric nursing facilities, which were poorly equipped to care for them. H.R.Rep. No. 100-391(I), at 459 (1987), *as reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-279. *Voss v. Rolland,* 592 F.3d 242, 247 (1st Cir. 2010). That Act prohibits states from using Medicaid funding for nursing home residents found, through a screening process, to need the level of care nursing homes provide, unless "specialized services" are provided to those patients. Id. *See also* 42 U.S.C. § 1396r(e)(7)(D)(ii) and 42 C.F.R. 431.120(a) at R. 595. That process of screening patients who are "mentally retarded" or mentally ill is referred to in those regulations as a "Preadmission Screening and Annual Resident Review (PASARR).[13] These requirements are contained at 42 C.F.R. 483.106.

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The Nursing Home Reform Act uses the term "mentally retarded" to refer to individuals who have mental retardation or " a related condition" as defined in another provision. 42 U.S.C. § 1396r(e)(7)(G)(ii). The regulations implementing this Act are contained at R. 613 of the Record in this case. The term "mental retardation" was used on the PASARR Level I and Level II screening form. R. 861. In other state and federal statutes and regulations, the term "mental retardation" has been replaced by the term "intellectual disability."

These screenings must be performed for every new admission to a nursing home, then at least annually thereafter.[14] Id. They must also be performed upon readmission of the patient after being hospitalized. Id. at 630.

First, in the Level I screening, the State must assess the patient to determine whether the nursing home resident is "mentally retarded" or “mentally ill.” The South Carolina Medicaid Provider Manual contains the requirements for performing PASARR’s. R. 857. Only if the resident is determined in the Level I screening is the Level II screening performed. The nursing home assessed Myers upon his admission on December 19, 2011 and determined that he has mental retardation or a related disability.

The South Carolina DHHS requirements for Level II PASARR’s are contained at R. 609, 610 and 857 to 865. The Level II screening was inexplicably signed on December 13, 2011 *before* Myers entered the nursing home and *before* the Level I screening was performed. When “specialized services are determined to be required, they must be provided by the South Carolina Department of Mental Health or the South Carolina Department of Disabilities and Special Needs. R. 857. In the Level II screening, the State determined that Al does not need specialized services. R. 657 to 660. 42 C.F.R. 483.128(a) specifically required that Myers’ legal representative (Mrs. Myers) be contacted to inform her of the evaluation. This was not done during the Level II evaluation, and, despite the clear and unambiguous requirement to involve the individual

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DHHS’ agent, the South Carolina Department of Disabilities and Special Needs (DDSN), has the responsibility to evaluate persons who have mental retardation. 42 C.F.R. 483.106(d)(2) at R. 659 and 859.

and his guardian in the evaluation, Myers' guardian received no notice of the screening. 42 C.F.R. 483.128(c). DDSN failed to meet the interdisciplinary coordination requirement of the regulation. 42 C.F.R. 438.128(d). Without contacting his physician, his service coordinator or his guardian, Brian K. Hawkins, determined that Myers only requires:

Services of lesser intensity to be provided or arranged by the nursing facility.... R. 659.

This evaluation fails to meet the requirements of federal regulations. 42 C.F.R. 483.128(I) required that Mr. Hawkins identify his professional title, which is not included on the form. It does not identify the field in which Mr. Hawkins' "MA" was obtained. 42 C.F.R. 438.128(i)(2) required the State to include a "summary of the medical and social history, including the strengths and weaknesses or developmental needs of the evaluated individual." He failed to include a comprehensive psychiatric evaluation or functional assessment required by 42 C.F.R. 431.128(i)(4), (5) and (6). R. 634. The federal regulations clearly require that if the history and examination are not performed by a physician "then a physician must review and concur with the conclusions." 42 C.F.R. 438.128(c). No physician concurred with Mr. Hawkins' determinations, and Myers' physician (who was never contacted in the PASARR process) identified specific specialized services Myers needed in the nursing home and clearly explained in her statement presented to the hearing officer why these services continued to be needed. R. 614. The screener did not even contact Myers' service coordinator to find out that dental services, psychological services, physical therapy, a speech device and other specialized

services were included in Myers existing plan of care. R. 392 to 393.

42 C.F.R. 483.120 defines Specialized services for persons who have intellectual disabilities (mental retardation). This regulation is included at page 632 of the Record. 42 C.F.R. 483.120(a)(2) defines these services as "the services specified by the State which, combined with services provided by the NF <u>or other service providers,</u> results in treatment which meets the requirements of § 483.440(a)(1). "Active treatment" is defined in § 483.440(1)(a) ,[15] which states:

> 1. (a) Standard: Active treatment.
>
> (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—
>
> (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and
>
> (ii) The prevention or deceleration of regression or loss of current optimal functional status.
>
> (2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

In paragraph (b), those regulations provide that:

> The State must provide or arrange for the provision of specialized services, in accordance with this subpart, to all NF residents with MI or MR whose needs are such that continuous supervision, treatment and training by qualified mental health or intellectual disability personnel is necessary, as identified by the screening provided in §483.130or §§ 483.134 and 483.136.

Pursuant to 42 C.F.R. § 483.440(1)(c), when "services of lesser intensity than specialized services" are required, those services must be provided by the nursing facility, instead of

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[15] See also 42 C.F.R. 435.1010.

DDSN.

The Level II screening also did not meet the clear and unambiguous requirements set forth in DHHS' own manual, which include:

Mini Mental State Exam

Consent Form

SC Long Term Care Assessment

Social History (Form 248)

Resident's history and physical completed by the physician

The social history form is included on page 860 of the Record. Having not contacted Myers' guardian, his physician or his DDSN service coordinator, the determination that specialized services are not needed was made without this required information. The consent form was never presented to Myers' guardian and his guardian was never provided the notice of appeals contained at page 863. R. 484.

The Record is devoid of <u>any</u> evidence from a qualified medical source, much less substantial evidence, that would support Mr. Hawkins' determination that Myers does not need "specialized services." The hearing officer acknowledged in her February 9, 2012 order that Myers continued to need a speech generating device, dental care and physical therapy, which she found to be covered Medicaid services. Yet, it is egregious that more than four years after this appeal was filed, Myers has never received the communications device, despite his guardian complaining about the failure to provide this device in her original appeal in 2010. R. 63(20). In Mrs. Myers' notice of appeal sent to the DHHS Office of Hearings and Appeals on February 11, 2010, she stated that:

> Specifically, I am opposing the cut to his hours of PCAII support, the elimination of his daily /24 hour in home respite, the eliminations of Physical Therapy, Occupational Therapy and *Speech Therapy services and the denial of coverage for Augmented Communications evaluation and equipment.*

R. 687. In Myers' Reply to Interlocutory Order dated March 15, 2010, he complained that DHHS had failed to provide waiver services in the amount, duration and scope necessary to prevent institutionalization (paragraph 10), specifically that:

> 13. Appellant was adversely affected by the elimination of speech and language services ...and his need for assistive communications equipment...

Myers' dental, psychological services and physical therapy were discontinued once he entered the nursing home and there is no evidence in the Record that support Respondent's claims that these services are available to him. R. 684. 1396a(a)(8) requires more than the State determining that a Medicaid participant might qualify for services at issue in the appeal.

In *Barker v. Riverside County Office of Education,* the plaintiff was intimidated and constructively terminated by the school district because she complained that defendant was not in compliance with requirements of federal and state law in how it provided educational services to its disabled students. 584 F.3d 821, 823 (9th Cir. 2009). The Court found that the anti-retaliation provisions of the Rehabilitation Act grants standing even to non-disabled people who are retaliated against for attempting to protect the rights of the disabled. Id. at 789. As noted by the Court in *Barker*, Section 504 incorporates the anti-retaliation provision of Title VI of the Civil Rights Act of 1964 by providing that "...the remedies, procedures, and rights set forth in title VI of the Civil

Rights Act of 1964 ... shall be available to *any person aggrieved by* any act or failure to act by any recipient of Federal assistance...." 29 U.S.C. § 794a(2) (emphasis added). Respondents have violated the anti-retaliation provision of Title VI of the Civil Rights Act which are incorporated by section 504. 34 C.F.R. § 100.7(e) (emphasis added). This regulation applies to all rights that are secured by the Rehabilitation Act pursuant to 34 C.F.R. § 104.61. The anti-retaliation provision in Title VI of the Civil Rights Act has been incorporated by the Rehabilitation Act so as to extend the Rehabilitation Act's protections to 'any individual,' such as Myers and his mother, who has been intimidated, threatened, coerced, or discriminated against ' for the purpose of interfering with [protected rights]' under Title VI of the Civil Rights Act or the Rehabilitation Act." *Barker* at 825 citing *Weber,* 212 F.3d at 48 (*quoting* 34 C.F.R. § 100.7(e)) (*citing* § 104.61) (granting standing under section 504 of the Rehabilitation Act to a mother who claimed the school system had retaliated against her personally for attempting to enforce her disabled child's rights). As with Section 504 of the Rehabilitation Act, the language employed in the anti-retaliation provisions of Title II does not demonstrate a congressional intent to limit the protections of the ADA to cases where the acts of the disabled person himself result in the retaliation. *Barker* at 827. The anti-retaliation provisions of the ADA recognize that persons with disabilities may need help from another non-disabled person to defend and vindicate their rights, as Mrs. Myers has done for her son and others across the State. Id.

When Mrs. Myers filed this appeal, DDSN threatened that parents would have to pay the State back for the cost of their adult children's services if they lost their appeals.

R. 482. Mrs. Myers organized a grass-roots organization called "South Carolina Voices" and became "communication central" by publishing a newsletter and sending daily emails informing parents across the State of their rights. R. 480 to 481. She informed parents that they could not be held liable for the cost of adult children's services if the child lost his or her appeal. Id. She testified that people she talked with around the State are "very scared of retaliation." E. 482. According to Mrs. Myers "It's a very real fear among parents" and she gave specific examples. Id. Parents in the Greenville area warned her that "...you really shouldn't be doing this." E. 483. Mrs. Myers testified that her son never received the adaptive communications device or nursing services that were ordered by his physician and included in his plan of care. DDSN determined on the PASARR evaluation that her son did not need any "specialized services" when he was admitted to the nursing home, without even contacting Myers' doctor, guardian, GAL or DDSN service coordinator to determine his needs. ("Specialized services include things like physical therapy, dental services, psychological services, companion services, etc. *Voss v. Rolland,* 592 F.3d 242 (1st Cir. 2010). Respondent has refused to pay for physical therapy services in the nursing home which are needed to prevent contractures. R. 484.

When this Court reversed the Respondent's decision to deny Myers and three other waiver participants a fair hearing, DDSN did not pursue action to reduce or terminate the services of the other three appellants. The Medicaid Act requires that services provided to Medicaid participants in a waiver program must be comparable. 42 C.F.R. 1396a(a)(10), and Respondent has violated that requirement. Myers guardian complained that only "ours was contested, yeah, I think there's some retaliation going

on." R. 488. Mrs. Myers was always fearful that DDSN would cut her son back to 28 hours and "that threat hanging over us that we might lose those hours." R. 491. Her worse dreams have come true.

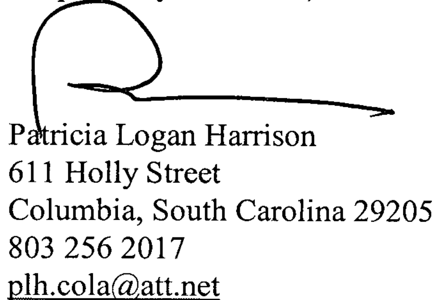
As this Court found in *Pridgen v. Ward*, government actors who retaliate against whistle blowers tend to be clandestine in their actions. 705 S.E.2d 58 (S.C. Ct. App. 2010). Retaliation may be proven by direct or circumstantial evidence. Id. In Myers' case he has provided direct evidence that he has been treated unfairly after his mother advocated openly against the 2010 reductions. Respondent selectively omitted documents from the Record, then the Administrative Law Court ruled against Myers based on one of those omitted documents. Not only was he not provided with a notice of appeal of Respondent's adverse decision on his PASRR evaluation, but the required consent and physician's report was not obtained. Yet, instead of correcting this egregious error, Respondent continues to deny critical services and fight tooth and nail to win, just as the State has done in *T.R. v. South Carolina Department of Corrections*, 2005 C.P. 400 2925 (Richland County Court of Common Pleas January 8, 2014).

The lower court erred in its determination that Respondent has not violated the anti-retaliation provisions contained in federal law, as identified above and its decision should be reversed, with DHHS and its agent, DDSN, ordered to provide the medically necessary services his physician determines that he needs. He has suffered long enough due to the retaliatory actions of Respondent.

V. Conclusion

Myers has presented credible medical evidence in support of the medical necessity of the services ordered by Dr. Munn and the State has failed to provide any medical evidence from a qualified source to contradict those orders. *Moore v. Cook*, No. 1:07-CV-631-TWT, 2012 WL 1380220, at *10 (N.D. *Ga.* June 19, 2012). For the reasons set forth above, Myers requests that this Court reverse the decision of the hearing officer. Myers requests that this Court exercise its equitable powers to order the Respondent to provide all of the services that Myers' treating physician determine to be medically necessary. In the alternative, Myers requests that this Court appoint a qualified independent examiner pursuant to 42 C.F.R. 431.240(b) to monitor his services and to assure that Myers will be free from further retaliation. Myers requests an order finding that he is the prevailing party in this case and requiring Respondent to pay attorney fees and costs.

Respectfully submitted,



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

Attorney for Appellant

June 4, 2014

Final March 18, 2015

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

The Hon. Shirley C. Robinson, Administrative Law Judge
Trial Court Case No. 2012ALJ080173AP

RECEIVED
MAR 20 2015
SC Court of Appeals

Appellate Case No. 2014-000418

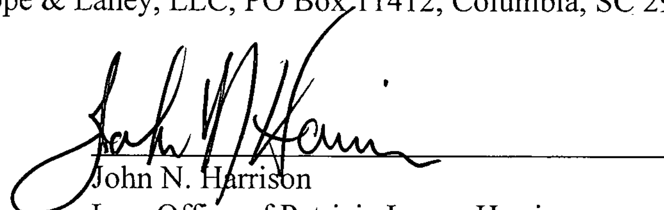
Albert C. Myers, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

CERTIFICATE OF SERVICE

John N. Harrison certifies that he served the *Final Initial Brief of Appellant* and the *Final Reply Brief of Appellant* in the above captioned case on the Respondent by U.S. Mail to Damon C. Wlodarczyk, Esq., Riley Pope & Laney, LLC, PO Box 11412, Columbia, SC 29211, on March 18, 2015.



John N. Harrison
Law Office of Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
(803) 256-2017