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IN THE STATE OF SOUTH CAROLINA

In the Court of Appeals

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SC Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
Administrative Law Court

Shirley C. Robinson, Administrative Law Judge
Case No . 2012ALJ080173AP

Albert Cooper Myers, ... Appellant,

v.

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

Appellate Case No. 2014-000418

RECORD ON APPEAL

VOLUME 2

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HEPFER: Just, just trying to be a very brief review and synopsis here of—you know, Al may need physical therapy. That's available under the State Plan. He may need a speech generating device. That's available under the Waiver according to Ms. Priest's testimony. He gets psychological services under the Waiver. Dental services, medical, nursing services are available, denied but not—but possible under the Waiver at least for the weekends. You know, the loss of Lisa was really a serious disruption of your care plan and but it doesn't seem like it was the Waiver cuts that were the cause of the institutionalization. It seems like a whole bunch of other things came together to cause the institutionalization not the least of which was your own aging and…

MYERS: There were a combination of factors.

HEPFER: Thank you.

MYERS: Well, he's talking right to me.

HARRISON: No, no.

(Laughter).

HARRISON: Sorry.

MYERS: Don't look at me.

HARRISON: He talks and we listen.

HEPFER: Anyhow…

MYERS: I'm sorry.

HEPFER: Anyhow, that, that's our position, that the Waiver in this case and we believe in most cases if not all cases is a combination of services that can be toggled together in a very creative mix of services to maintain people. The notice problem, the feasible alternatives, the PASRR, I'm not sure I understand what the argument is there but the Administrative Law Judge dealt with the notice problem and certainly by now we should be beyond a notice and we've talked about all of the services that are available and as far as the PASRR goes, he's only been in the facility for a couple of weeks. I don't know. They may not even have finished completely the

Level II, I just don't know but anyhow, that's all I have to say, you know. I'll be happy to turn it over to Ms. Harrison.

HARRISON: I'm not going to be as brief. I'd like to have both of you follow me with this on the Olmstead decision and I would also like to go ahead and make sure we have in the record the report and recommendation, did I give you that?

HEPFER: Yes.

HARRISON: I gave you that one. I gave you the report and recommendation?

SCHINDLER: Yes.

HARRISON: And the—did I also give you the…

SCHINDLER: And I have Olmstead.

HARRISON: …the order? Okay, but here's the order and opinion in that case. What this Agency has ignored and the most controlling of all the controlling law in this case, if you'll turn to page 17 of the Olmstead decision and it's page 610 in the decision in the US report. In that decision the concurring opinion of Justice Kennedy, the opinion of a reasonable treating physician in determining the appropriate conditions for treatment ought to be given the greatest deference and then again down here in the last paragraph, with great deference to the medical decisions of the responsible treating physician. What we've seen here today is that things were very fragile, that they deteriorated when we have the service coordinator and we have the DDSN official saying we don't pay any attention. That's just one of those things we consider in the basket. It's not any more important than anything else. And what we heard the service coordinator saying was well, I talk to the family and I look at this and it's obvious that it's very arbitrary because based on the factors she says she considers, she could not have come up with that result to deny nursing particularly on the days that he didn't attend the day program but we've also got the issue and this is one of the frustra—most of my work I deal with DDSN. This is one of the most frustrating things that I have encountered is that it really doesn't matter what you say. It doesn't matter what the Federal Court says. It

doesn't matter what the Administrative Law Court says. They will continue to do things the way they choose to do them. We've now had two binding norm cases, the Hickey case, the consolidated case that this is a part of, saying those cuts are illegal. Those are unenforceable because you didn't promulgate them as regulations. We also have and I've provided in my material a decision that came out that I argued before the South Carolina Supreme Court that came out December 28th, Jane Doe versus HHS that also says you've got to promulgate regulations if you're going ...o restrict. In that case it was eligibility so what we have, we've had the person who is in charge of this program in this Agency. We've had the person who is in charge of the Agency at DDSN saying no, we hadn't—we don't talk about promulgating regulations. We're going to continue to do it our way. We also have the Doe v. Kidd decision which has now gone up to the Fourth Circuit twice because the first time when the Fourth Circuit said you must provide residential habilitation with reasonable promptness and then several years later they still haven't done it and it went back up and fortunately for me they determined we're the prevailing party and awarded legal fees and said you have to provide residential habilitation with reasonable promptness so what we've seen is an out of control agency that pays no attention to what the court says, to what the ALJ said. We've got a decision saying that was a binding norm and it's unenforceable but we're still hearing them argue, well, we're capping his services. And why is this important for Al? For the time being, you've heard Ms. Myers talk about fear of retaliation which is a very real fear for families. For the time being she has lost the battle and he's in the nursing home, for the time being. But if the decision of—the first decision saying those caps apply, can apply to Al, if that's upheld, that does away with his ability to get out of the institution because we've heard here today that if he doesn't have these additional services, he's never going to get out of the institution. So it's very important that the decision of the ALJ, that that is a binding norm and you can't cap services

being upheld by this court, regardless of the fact that he is now in the institution. Without that he doesn't get out. We've had decisions, we've had the Marlow M. decision and the District Court in North Carolina and the Federal Court saying you've got to provide 24/7 services. We have had decisions all over the Court, Disability Action Center in New York. We've had the Cra...tree case. What we're hearing these people saying is well, CMS approved it, therefore, it's law. Well, Federal Courts around the country are saying that's not true. In Tennessee in Crabtree versus Goitz, CMS had approved the cuts and the Federal court said we don't care whether they approved the cuts or not. And our own State in a case that involves and I don't know if the Hearing Officer is aware of this, but Chip E. and Michelle M. are two of the—are two of the individuals who are in this consolidated case and in the report and recommendation in the Order, what the Federal Court said and it was in a preliminary injunction which is really harder to get than a decision, that these—it doesn't, it doesn't matter if there's caps, you still have to provide the services under the ADA, separate and apart from what Medicaid says. Under the Americans with Disabilities Act, if a person has a disability, if a person, if a person the State's determined they could live in the community which they've done with Al. He was one of the first ones on the Waiver, and he did successfully for years when appropriate services were being provided and if he doesn't oppose institutionalization so he has a choice but if you don't upheld the ALJ decision, that door, if you can go back through, right now he's where unfortunately with the state of the situation and the fear of retaliation, the concerns that are on the table, right now he is in a nursing home. But Ms. Myers doesn't want to close that door so that these caps are applied only to Al. Isn't it odd, the caps are only applicable to Al? The caps for Chip E. and Michelle M., they're not applicable to them. They're continuing to receive the services because the ALJ said that it was a binding norm that was unenforceable. But the Agency with the testimony you've heard, totally ignoring the opinions of the treating

physicians said no, we're going to give them the services but we're not going to give them to Al Myers. Well, why is that? And we have—I have somewhere here, I'll find i... in a minute, the Americans with Disabilities Act, there's an anti-retaliation provision and I have a case as I'm wrapping up I'll—if it's okay, I'll pass it on to ya'll, there is a case from the Ninth Circuit where a speech teacher advocated for her students and because she advocated, she got fired so to be the person who's retaliated against doesn't have to necessarily be the disabled person. People who do what Ms. Myers has done, getting on that computer, getting the information out across the State, letting people know you have a right to appeal this, you can do this, letting people know wait a minute, this is coming, watch out for this, gathering information, the American's with Disabilities Act not only does it say that Al has a right to live in the least restrictive setting and to receive the services he needs in that setting, but it also says that when someone like his mother advocates for him, it is a violation of the law to retaliate against her and what we've got here is four people going up and only Al was determined to not be able to exceed the caps. So we, we, and I'm sorry I can't put my hand on it right now but I'll give you that...

HEPFER: (Unclear) under the table right (unclear)?

HARRISON: No, it's here somewhere. We've also got the violation—so under the Integration Mandate, Congress determined that forcing people like Al to be in a segregated setting is discrimination. It's just like telling a black child you can't go to a white school. You're, you're, you're going to have to go with other people who are like you. Years ago that was the case and our schools are better places because we have all kinds of peoples in school. We have rich people, poor people, Chinese people, black people, white people, and it wasn't always that way. Well, it's the same kind of thing we're doing now with the violation of the Integration Mandate forcing people like Al to go into an institution. They're segregating him. Now, what Congress said though was when that has to happen as it's—because of the turn of events it's happened here, they require

PASRR and 1396 R and the regulations that are start around page 25 and go on, those are the PASRR requirements and what the PASRR says is that the nursing home has to determine does he have mental retardation or a related disability and they determined that and then it goes over to DDSN and then DDSN says well, this person can get along with just nursing home services, or well, this person needs specialized services in addition to what the nursing home provides. That's what that form is all about and I have included in here the Roland versus Romney, it was initially Roland versus and I'm linguistically disabled, C-E-L-L-U-C-C-I, Cellucci, Cellucci, whatever, and in that case and you can see the development of it, the Federal Court said if somebody's in an institution, if they have MR or a related disability, you have to provide them specialized services. You have to provide them socialization opportunities, not going down the hall and playing bingo with the old people or listening to the Old Langsyne and the things that people that are 75 and above, the Big Band music but you have to give them the opportunity to go out into the community. You have to give them the augmentative communication devices they need. You have to give them the PT. You have to give them all these—dental care. Dental care in the nursing home is only provided if the—if it's an emergency or to pull teeth. They don't provide the—Al has to be put to sleep to just have his teeth cleaned. Without the specialized services provided through PASRR, Al won't have that and we've heard testimony today who have—from people who have years and years of experience that what will happen is that he'll get infections, he'll get sick, there'll be—and Al, I don't know how many of you have ever had a toothache, I haven't had one in years, thank goodness, but as a kid when you have a toothache and everything hurts, imagine that when you can't say mom, I need to go to the dentist. My tooth hurts, it's this one. Al can't do that. Al can't say it's my tooth. He can—if you guess it right by looking right or left, he can, he can give you a hint about what it is but he can't tell you that and the PASRR regulations say and the 1396 R says that

what you have to provide to a person who is in an institution is, is active treatment and it refers back to the active treatment services that are provided in an ICFMR. Now Roland V., Cellucci, Romney, goes into all of this in greater detail than we have time for me to go into right now but Al is entitled—he lost the war for now with staying home with mom but he is entitled to receive those services and if this PASRR is allowed to stand that wIs done by DDSN without even talking—the regulations also talk about what information has to be gathered to do the PASRR. They're supposed to go out, they're supposed to get medical information, they're supposed to get social information. We have somebody that Ms. Myers testified she's never heard from him, she doesn't know who he is, he's somebody with a Master's Degree. He signed a PASRR saying no specialized services are needed for this individual and that gets right back and in one of these papers I also have the State Plan, discussion of medically nec—the State Plan, Medicaid Plan, says that if services are medically necessary, except where limited, that they have to be except, except if there's a, a restriction in the State Plan, I'm talking about State Plan services here. I'm not talking about Waiver services then they have to be provided and Al needs these services, he's not going to get them with the PASRR evaluation and you know we heard, well, did you appeal the nursing? What we have here, one parent called it a death by a thousand cups. This is, this is the, at least the second appeal. Ms. Myers was part of the group hearing and I should have asked her how much the transcript cost. We've got parents, it's like a hamster wheel. You look at Doe v. Kidd, between the State Administrative cases and the Fourth Circuit and the District, that has been going on for eight years and what happens with a little chipping away, is we have a gradual decline and mom can't afford—she couldn't afford today if it weren't for my not charging her for being here today. Families can't afford this. So the idea well, did you appeal it? Just appeal the next one and the next one and the next one and these cuts are coming faster than parents can even keep up

with them and they certainly can't afford legal services to protect their rights. Under the Medicaid Act, we clearly have a deficient notice and this is subject to repetition but it evades review. I've seen decisions from here and from ALJ saying well the notice was dIfective. Not in this one but in other ones and what happens is then the person goes back and she's subject, if they don't provide a PT, if they don't provide the augmentative device within 90 days and it's been more than 90 days since she's asked for it, she's subject to this again and she's not getting here and she didn't get a notice, you know the Reg's and the cases talk about how when get the PASRR, you're supposed to be given a notice you could appeal this. She'd never seen it. So we have this on-going situation with a lack of notice and a defective notice that isn't going to get better unless they're held accountable for it. The reasonable promptness issue, we have evidence that in June she asked for nursing services and they still hadn't been provided. Based on some manual that now the South Carolina Supreme Court in Doe v. HHS and these various ALJ cases have said it's a binding norm. It doesn't count. You can't do that. You can't restrict a person's right to medically necessary services by a manual or even by CMS, the Regional Office at CMS agreeing to a Waiver amendment. That was the argument that was made in Peter B., a case that involved two of these appellants in this consolidated case. And the Federal judge said, no, I don't care if CMS approved it or not, it violates the ADA. We also have the feasible ser—alternatives issue. And that's another one subject to repetition yet it evades review. Mom is going to be needing—she didn't, she didn't—nobody told her, if she didn't happen to have an attorney that typically works for free, she never would have known there were specialized services. Al would have contracted until he eventually choked or something happened to him. So we've got a violation of the feasible alternatives. She wasn't told about specialized services. She hadn't been told about nursing. All of these things unless we start holding—requiring them to comply with the Act, we're going to continue to see this.

Amount, duration and scope, we have violated because the regulation and law says that each service has to be in the amount, duration and scope. What we heard Ms. Priest testify was well, it meets the needs of most of the people. That's not good enough. That's what the court said in Peter B., it's not good enough to meet the needs of most of the people. If you design the plan and if you do specialized services so it meets most of the needs, then people like Al Myers who has severe disabilities, are being discriminated against. And each service has to be sufficient in agount, duration and scope. We've talked about the PASRR issue. I would bring up on the ADA issue, if the person's disabled, if they've been determined to be able to live in the community, and if they don't oppose treatment, then the burden is on the State to prove that that would cause a fundamental alteration in their system. And there's a lot of cases I know at the ADA, the Crabtree case and the Disabilities case in New York, Disabilities, I'm tired, Disabilities, I can get that site to you if I'm allowed to.

HEPFER: The New York.

HARRISON: The New York case. Now Mr. Hepfer brought to the attention the Washington case, the M.R. and there's a number of initials but it starts with M.R., not for mental retardation but the person's initials were M.R., I would—I have included in this the Ninth Circuit case that went up to the Ninth Circuit on appeal and it was reversed so I believe that's an ADA case but that is no longer good law because the, the Ninth Circuit granted the preliminary injunction that had been denied at the lower level. We have the retaliation issue and I've mentioned that briefly. I have in here the regulations that—I'm sorry, I will find before I pack up, the regulation that says it's a violation of—it's a violation of the ADA to retaliate against somebody for advocating. So you know our primary argument—and here's a M.R. case, it's 162, page 162. It's the Ninth Circuit MR case that reversed the case that Mr. Hepfer provided the Hearing Officer so and I think I have also—I want to give you everything that I'm supposed to give

you, the—and do you need this, this is just 13—I'm sorry, this is, no, I've given you all—have I given ya'll this?

SCHINDLER: I don't believe I have that one.

HARRISON: Okay, let me look at that and see if there's—have you got a copy?

HEPFER: (Unclear)?

HARRISON: Yeah.

HEPFER: (Unclear) speak for themselves.

HARRISON: Let me make sure that's all that's in there.

HEPFER: (Unclear).

HARRISON: I'm sorry, this is 1396 A. This is a reasonable promptness provision, the other issue is that there's a provision in 1396 A. A. that says you have to provide comparable services to other people with disabilities. Well, obviously they've violated that. They're saying that these other three individuals can exceed the cap and they have disabilities that are no more significant than—they're very significant disabilities, I don't mean they're not significant but, but they are—Al's disabilities are just as great as theirs so it also violates the comparability provision of 1396 A.A. So, you know, we've obviously got a situation where they have ignored the, the treating physician in violation of Olmstead. They've ignored the holding of the ALJ that this is a binding norm. And you can't enforce it. So we would ask, Your Honor, that you issue a ruling saying that because the Waiver amendments are a binding norm, that, that they're not enforceable to give Al the possibility of getting out of the nursing home. We would also ask that the medically necessary services that he needs to remain in the community be provided to him. And I'll find that—I apologize for being so disorganized. We didn't have much time to get ready...

HEPFER: You can send it later if you want.

HARRISON: ...ready for this. Can I provide you those sites?

SCHINDLER: Yes.

HARRISON: Okay. And I apologize, between Christmas and the short notice on this, after the remand, I'm not as prepared as I'd like to be.

SCHINDLER: All right, is that it?

HEPFER: Well, I would just encourage the Hearing Officer to make your own mind up about what the cases say and also I thought this case was about services in the community not services in the nursing home but—at least that was the initial one.

SCHINDLER: Ms. Harrison, can you get me those citings or whatever by next Friday? Would that give you enough time? That would be…

HARRISON: And I might be able to get it packing up.

SCHINDLER: You might find it as you go through yourself. Yeah, that would be I guess January 13th would be the date. All right, we're off the record.

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Office of General Counsel

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Susan Edge, Appellant, vs. South Carolina Department of Health and Human Services, Respondent.	Docket No. 10-ALJ-08-0501-AP ORDER
Jimmy W. Eubanks, Jr., Appellant, vs. South Carolina Department of Health and Human Services, Respondent.	Docket No. 10-ALJ-08-0502-AP
Michelle Morgan, Appellant, vs. South Carolina Department of Health and Human Services, Respondent.	Docket No. 10-ALJ-08-0503-AP
Albert Cooper Myers, Appellant, vs. South Carolina Department of Health and Human Services, Respondent.	Docket No. 10-ALJ-08-0504-AP

APPEALS & HEARINGS
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SC ADMIN. LAW COURT

HO EXHIBIT
1

I. STATEMENT OF THE CASE

These matters are before the South Carolina Administrative Law Court ("ALC" or "Court") in its appellate jurisdiction pursuant to S.C. Code Ann. § 1-23-600(D) (Supp. 2010). Susan Edge, Jimmy W. Eubanks, Jr., Michelle Morgan, and Albert Cooper Myers ("Appellants") appeal the final administrative decisions of the South Carolina Department of Health and Human Services ("HHS") to reduce or discontinue services and/or supplies under the Mental Retardation/Related Disabilities ("MR/RD") waiver program.[1] The changes concerning the MR/RD waiver program were imposed as a consequence of substantial reductions in State budget appropriations for the agency.

Upon careful review of these matters, considering the Record on Appeal, the briefs, and applicable law, these matters must be remanded to HHS to conduct evidentiary hearings for each individual.

II. FACTUAL BACKGROUND

A. Susan Edge

Susan Edge ("Edge") is a recipient of Medicaid Services and is currently receiving services under the MR/RD waiver program, a federally approved and state-administered Medicaid program. On January 1, 2010, the five-year renewal of the MR/RD waiver was approved by the Center for Medicare and Medicaid Services ("CMS"). The renewed waiver included a cap or limit on some services and termination of some prior authorized services. Prior to the MR/RD waiver renewal on January 1, 2010, Edge was authorized to receive 32 cases, annually, of liquid nutrition. Under the renewal of the MR/RD waiver, Edge was authorized to receive the cap of 24 cases, annually, of liquid nutrition.

B. Jimmy W. Eubanks, Jr.

Jimmy W. Eubanks, Jr. ("Eubanks") is a recipient of Medicaid Services and is currently receiving services under the MR/RD waiver program. Prior to the MR/RD waiver renewal on January 1, 2010, Eubanks was authorized to receive fifty-two (52) hours of Personal Care Aide II services per week and one hundred four (104) hours of Respite Care per week. After the renewal was effective, Eubanks' Personal Care Aide services were reduced to twenty-eight (28) hours per week; however, he did not receive a reduction of services regarding Respite Care.

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[1] Each Appellant filed an individual appeal to challenge HHS's decisions. After the appeals were made to the ALC, by order dated October 4, 2010, the four individual appeals were consolidated as each concerned the same question of law.

C. Michelle Morgan

Michelle Morgan ("Morgan") is a recipient of Medicaid Services and is currently receiving services under the MR/RD waiver program. Prior to the MR/RD waiver renewal on January 1, 2010, Morgan was authorized to receive fifty-six (56) hours of Personal Care Aide II services per week. After the renewal was effective, Morgan's Personal Care Aide services were reduced to twenty-eight (28) hours per week.

D. Albert Cooper Myers

Albert Cooper Myers ("Myers") is a recipient of Medicaid Services and is currently receiving services under the MR/RD waiver program. Prior to the MR/RD waiver renewal on January 1, 2010, Myers was authorized to receive the following: Dental; 5 units per week of Community Services; 5 units per week of Day Activity; Specialized Medical Equipment; Supplies and Assistive Technology – Peri Wash; Attend Wash clothes; Diapers; 4 units per week of Physical Therapy; 45 hours per week of Personal Care Aide II services; 48 units annually of Daily Respite; and 456 units annually of Hourly Respite. After the renewal was effective, Myers' retained the same authorized services as modified: twenty eight (28) hours per week of Personal Care Aide II services; twenty-four (24) units per week of Personal Care Aide I services; and sixty-eight (68) units per month of Respite care, with an exception granting Myers an additional 33 units per month (for a total of 101 units of Respite Care per month).

III. PROCEDURAL BACKGROUND

A. Susan Edge

On January 19, 2010, the Director of the South Carolina Department of Disabilities and Special Needs ("DDSN") notified Edge in writing that the decision to reduce her services based upon the MR/RD waiver renewal on January 1, 2010 was upheld. DDSN upheld the decision based upon its inability to exceed the established limits of the MR/RD waiver. On February 12, 2010, Edge, through counsel, appealed the decision to reduce her services. On March 3, 2010, the Department's hearing officer issued an Interlocutory Order asking Edge for a written statement of any allegation of any error made by the agency in its modification of the Medicaid sponsored waiver services provided through DDSN.[2] Edge responded to the Interlocutory Order on March 22, 2010, and counsel for the

[2] A revised Interlocutory Order was sent to counsel on March 5, 2010, which corrected a typographical error in the original order.

Department submitted his reply to the allegations contained within Edge's response to the Interlocutory Order. Based upon the filings made by each party, the Department hearing officer issued an Order of Dismissal on May 12, 2010. No evidentiary hearing was conducted prior to the hearing officer's Order of Dismissal.

Based upon Edge's filings, the Department hearing officer determined that her arguments concerned the validity of the modified MR/RD waiver limits, effective January 1, 2010, and no argument was made concerning the application of the waiver program limits to Edge, individually. In the order, the hearing officer determined that Edge failed to state any error of law with regard to the new limits of the waiver program, and thus, the appeal was dismissed. On May 26, 2010, Edge submitted a motion for reconsideration of the hearing officer's May 12, 2010 Order of Dismissal. On June 18, 2010, Edge filed a Notice of Appeal with the ALC to challenge the Department's May 12, 2010 Order of Dismissal. To date, the Department hearing officer has not ruled upon Edge's motion for reconsideration.

B. Jimmy W. Eubanks, Jr.

On January 11, 2010, the Director of DDSN notified Eubanks, through counsel, in writing that the decision to reduce his services based upon the MR/RD waiver renewal on January 1, 2010 was upheld. DDSN upheld the decision based upon its inability to exceed the established limits of the MR/RD waiver. On February 5, 2010, the Department's hearing officer issued an Interlocutory Order asking Eubanks for a written statement of any allegation of any error made by the agency in its modification of the Medicaid sponsored waiver services provided through DDSN. Eubanks responded to the Interlocutory Order on February 24, 2010, and counsel for the Department submitted his reply to the allegations contained within Eubanks' response to the Interlocutory Order. Based upon the filings made by the parties, the Department hearing officer issued an Order of Dismissal on April 29, 2010. No evidentiary hearing was conducted prior to the hearing officer's Order of Dismissal.

Based upon Eubanks' filings, the Department hearing officer determined that Eubanks' arguments concerned the validity of the modified MR/RD waiver limits, effective January 1, 2010, and no argument was made concerning the application of the waiver program limits to Eubanks, individually. In the order, the hearing officer determined that Eubanks failed to state any error of law with regard to the new limits of the waiver program, and thus, the appeal was dismissed. On May

17, 2010, Eubanks submitted a motion for reconsideration of the hearing officer's April 29, 2010 Order of Dismissal. On June 18, 2010, Eubanks filed a Notice of Appeal with the ALC to challenge the Department's May 17, 2010 Order of Dismissal. The Department hearing officer denied Eubanks' motion for reconsideration on May 24, 2010.

C. Michelle Morgan

On January 13, 2010, the Director of DDSN notified Morgan, through counsel, in writing that the decision to reduce her services based upon the MR/RD waiver renewal on January 1, 2010 was upheld. DDSN upheld the decision based upon its inability to exceed the established limits of the MR/RD waiver. On February 11, 2010, Morgan appealed the decision to reduce her services. On March 1, 2010, the Department's hearing officer issued an Interlocutory Order asking Morgan for a written statement of any allegation of any error made by the agency in its modification of the Medicaid sponsored waiver services provided through DDSN. Morgan responded to the Interlocutory Order on March 18, 2010, and counsel for the Department submitted his reply to the allegations contained within Morgan's response to the Interlocutory Order. Based upon the filings made by each party, the Department hearing officer issued an Order of Dismissal on May 17, 2010. No evidentiary hearing was conducted prior to the hearing officer's Order of Dismissal.

Based upon Morgan's filings, the Department hearing officer determined that her arguments concerned the validity of the modified MR/RD waiver limits, effective January 1, 2010, and no argument was made concerning the application of the waiver program limits to Morgan, individually. In the order, the hearing officer determined that Morgan failed to state any error of law with regard to the new limits of the waiver program, and thus, the appeal was dismissed. On June 1, 2010, Morgan submitted a motion for reconsideration of the hearing officer's May 17, 2010 Order of Dismissal. On June 18, 2010, Morgan filed a Notice of Appeal with the ALC to challenge the Department's May 17, 2010 Order of Dismissal. The Department hearing officer denied Morgan's motion for reconsideration on August 8, 2010.

D. Albert Cooper Myers

On January 13, 2010, the Director of DDSN notified Myers in writing that the decision to reduce his services based upon the MR/RD waiver renewal on January 1, 2010 was upheld. DDSN upheld the decision based upon its inability to exceed the established limits of the MR/RD waiver. On February 25, 2010, the Department's hearing officer issued an Interlocutory Order asking Myers

and/or his representative for a written statement of any allegation of any error made by the agency in its modification of the Medicaid sponsored waiver services provided through DDSN. Myers' counsel responded to the Interlocutory Order on March 15, 2010, and counsel for the Department submitted his reply to the allegations contained within Myers' response to the Interlocutory Order Based upon the filings made by Myers, the Department hearing officer issued an Order of Dismissa on May 6, 2010. No evidentiary hearing was conducted prior to the hearing officer's Order o Dismissal.

Based upon Myers' filings, the Department hearing officer determined that his arguments concerned the validity of the modified MR/RD waiver limits, effective January 1, 2010, and no argument was made concerning the application of the waiver program limits to Myers, individually. In the order, the hearing officer determined that Myers failed to state any error of law with regard to the new limits of the waiver program, and thus, the appeal was dismissed. On May 21, 2010, Myers submitted a motion for reconsideration of the hearing officer's May 6, 2010 Order of Dismissal. On June 18, 2010, Myers filed a Notice of Appeal with the ALC to challenge the Department's May 6, 2010 Order of Dismissal. To date, the Department hearing officer has not ruled upon Myers' motion for reconsideration.

E. Filings in Other Forums

i. South Carolina Supreme Court

Appellants, among others, filed a Petition with the South Carolina Supreme Court in December 2009 and requested the Court to issue an injunction to prevent the changes to the MR/RD waiver program becoming effective January 1, 2010. The Petition was denied on February 4, 2010.

ii. United States District Court, District of South Carolina

Appellants Eubanks and Morgan (and another unrelated plaintiff) filed a petition in the United States District Court, District of South Carolina, Greenville Division and alleged that the reduction in their services provided under the state's MR/RD waiver program violated the Americans with Disabilities Act ("ADA"). In their filings, Eubanks and Morgan seek declaratory and injunctive relief for alleged violations of the ADA. On November 24, 2010, a federal magistrate judge issued a Report and Recommendation that recommended that the Department be ordered to maintain and/or return services to the quality enjoyed by Eubanks and Morgan prior to January 1, 2010. To date, a federal district judge has not ruled upon Eubanks and Morgan's motion for preliminary injunction.

F. Procedural History of consolidated cases before the ALC

On September 15, 2010, Appellants filed a motion for extension of time and consolidation. The Department filed a return to the motion and cross-motion to dismiss on September 24, 2010. In its motion to dismiss, the Department argued that Appellants did not timely file their appeals as the motions for reconsideration did not toll the time to file the notice of appeals with the ALC. Appellants filed their replies on October 12, 2010.

By order dated October 4, 2010, the undersigned consolidated the individual appeals of Appellants. Further, the Court denied the department's motion to dismiss. The Court determined that the motions for reconsideration were valid, and pursuant to Rule 59(e), SCRCP, stayed the time for an appeal for all parties. On February 18, 2011, Appellants filed their brief, and the Department filed its appellate brief on March 22, 2011. Appellants filed a reply brief on April 4, 2011.

IV. ISSUES ON APPEAL

Appellants raise the following issues on appeal:

1. Have the Appellants' due process rights to be heard before an unbiased tribunal been violated by the Department because the hearing officers were predisposed to rule against them?

2. Has the Department violated 42 U.S.C. 1396a(a)(3), the requirements of 42 C.F.R. 431.210 and the Appellants' constitutional due process rights by failing to provide evidentiary hearings and a final decision within ninety days of Appellants' requests for a fair hearing?

V. STANDARD OF REVIEW

This Court's appellate review of final decisions of the Department is governed by standards provided in S.C. Code Ann. § 1-23-380. See also S.C. Code Ann. § 1-23-600(E). Section 1-23-380 provides that this Court "may not substitute its judgment for the judgment of the [Department] as to the weight of the evidence on questions of fact." § 1-23-380(5). However, this Court, pursuant to § 1-23-380(5),

> may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:
> (a) in violation of constitutional or statutory provisions;
> (b) in excess of the statutory authority of the [Respondent];
> (c) made upon unlawful procedure;
> (d) affected by other error of law;

(e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
(f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Id.; see also Lark v. Bi-Lo, Inc., 276 S.C. 130, 276 S.E.2d 304 (1981) (stating "'[s]ubstantial evidence' is not a mere scintilla of evidence nor the evidence viewed blindly from one side of the case, but is evidence which, considering the Record as a whole, would allow reasonable minds to reach the conclusion that the administrative agency reached or must have reached in order to justify its action.") Id. at 135, 276 S.E.2d at 306. "The findings of the agency are presumed correct and will be set aside only if unsupported by substantial evidence." Hull v. Spartanburg County Assessor, 372 S.C. 420, 424, 341 S.E.2d 909, 911 (Ct. App. 2007) (citing Kearse v. State Health and Human Servs. Fin. Comm'n, 318 S.C. 198, 200, 456 S.E.2d 892, 893 (1995). Accordingly, "[t]he 'possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's finding from being supported by substantial evidence.'" Grant v. S.C. Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995) (citing Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm., 282 S.C. 430, 432, 319 S.E.2d 695, 696 (1984)).

Further, an abuse of discretion occurs when an administrative agency's ruling is based upon an error of law, such as application of the wrong legal principle; or, when based upon factual conclusions, the ruling is without evidentiary support; or, when the trial court is vested with discretion, but the ruling reveals no discretion was exercised; or, when the ruling does not fall within the range of permissible decisions applicable in a particular case, such that it may be deemed arbitrary and capricious. State v. Allen, 370 S.C. 88, 94, 634 S.E.2d 653, 656 (2006) (application of standard to circuit court), citing Fontaine v. Peitz, 291 S.C. 536, 539, 354 S.E.2d 565, 566 (1987); see also Converse Power Corp, 350 S.C. 39, 47 564 S.E.2d 341, 345 (Ct. App. 2002), quoting Deese v. State Bd. of Dentistry, 286 S.C. 182, 184-85, 332 S.E.2d 539, 541 (Ct. App. 1985) ("A decision is arbitrary if it is without a rational basis, is based alone on one's will and not upon any course of reasoning and exercise of judgment, is made at pleasure, without adequate determining principles, or is governed by no fixed rules or standards.").

SEE YOU

VI. DISCUSSION

A. Generally

i. Medicaid

Medicaid is an optional state program created under Title XIX of the Social Security Act. It enables states to receive federal financial assistance specifically for the medical care of needy individuals. See 42 C.F.R. § 1396; Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007). States are not required to participate in Medicaid; however, if they choose to do so, they must comply with all federal Medicaid laws and regulations. Wilder, 496 U.S. 498; Doe, 501 F.3d at 351; see also Antrican v. Odom, 290 F.3d 178 (4th Cir. 2002) ("Although North Carolina may retain a special sovereignty interest in choosing whether to participate in the Medicaid program, once it elects to participate, it is not entitled to assert that interest to insulate itself from the requirements of the federal program."), cert. denied, Odom v. Antrican, 537 U.S. 973 (2002). As a prerequisite to receiving federal assistance, a state must submit a detailed plan, referred to as the "State Plan," to the Center for Medicare/Medicaid Services ("CMS") for approval. 42 C.F.R. § 1396a.

In South Carolina, HHS is the state agency responsible for administering and supervising the state's Medicaid programs. S.C. Code Ann. § 44-6-30(1); Doe, 501 F.3d at 351. Furthermore, DDSN is responsible for the state's treatment and training programs for people with mental retardation and related disabilities. Doe, 501 F.3d at 351. Accordingly, in some instances, such as the case at hand, DDSN can act as an agent for HHS. Id.

Medicaid provides funding for state-run homes and community-based care through a waiver program. See 42 C.F.R. § 1396n(c). The waiver program provides Medicaid reimbursement to participant states for providing community-based services to individuals who would otherwise require institutional care. Id. In this appeal, the waiver program at issue is the MR/RD waiver Program.

ii. MR/RD Waiver Program

States must seek approval for these waiver programs from the CMS. If a waiver is approved, the CMS waives compliance with state program requirements while permitting states to remain eligible for reimbursement with federal grants. Id. Waivers are approved for a period of two to three years and may be renewed thereafter. Under a program operated by DDSN, CMS has waived the

requirement that an individual live in an institution to receive services. The MR/RD Waiver Program permits a recipient to receive services at home or in the community, rather than in an Intermediate Care Facility for the Mentally Retarded ("ICF/MR") such as a nursing home. Doe, 501 F.3d at 351.

After receiving approval from CMS, South Carolina's MR/RD waiver renewal became effective on January 1, 2010.

B. Department Hearing Officers

Appellants assert that a fundamental element of due process is that a hearing must be provided before an unbiased tribunal. Because the hearing officers are employed by the Department, Appellants essentially argue that their due process rights have been violated because the hearing officers are predisposed to rule in favor of their employer, the Department. Further, Appellants argue that the Department participated in ex parte communications with DDSN.

It is well-settled that "[a] fair trial in a fair tribunal is a basic requirement of due process, [and] [t]his applies to administrative agencies which adjudicate as well as to courts." Garris v. Governing Bd. of South Carolina Reinsurance Facility, 333 S.C. 432, 443, 511 S.E.2d 48, 54 (1998) (quoting Withrow v. Larkin, 421 U.S. 35, 46, 95 S.Ct. 1456, 1464, 43 L.Ed.2d 712, 723 (1975)). The simple fact that "investigative, prosecutorial, and adjudicative functions are performed within the same agency, or even performed by the same persons within an agency, does not, without more, constitute a violation of due process." Garris, 333 S.C. at 443, 511 S.E.2d at 54. Furthermore, "[a]gency official or members who adjudicate a matter are presumed to be honest, fair, and unbiased." Id. at 444, 511 S.E.2d at 54.

In this matter, the fact that the hearing officers are employed by the Department does not, alone, constitute a violation of due process. See Babcock Center, Inc., v. Office of Audits, 286 S.C. 398, 334 S.E.2d 112 (1985) (holding that administrative agency may adjudicate appeals by panels composed of other persons within the same agency who did not participate in investigative or prosecutorial capacities). Unlike the administrative process outlined in Garris, the hearing officers do not conduct any investigative or prosecutorial functions; rather, the hearing officers serve only in an adjudicatory capacity. There is simply nothing in the record to indicate that the hearing officers were "predisposed" to rule against the Appellants by the mere fact that the hearing officers were employed by the Department.

Appellants next argue that they are unable to receive a hearing before an unbiased tribunal based upon the following allegations: 1) employees of the Department participated in ex parte communication with the Department's Division of Hearings and Appeals and employees of DDSN; 2) the Department and its hearing officers intentionally omitted documents from the record on appeal; and 3) the Department argued in other judicial forums Appellants' cases should be dismissed so that the cases can be litigated in the state administrative appeals process while simultaneously arguing before the ALC that the appeals before the ALC should be dismissed.

i. Ex parte Communication

On February 18, 2010, the MR/RD waiver program coordinator for DDSN sent a memorandum to the Director of the Department's Division of Appeals concerning the reductions in service for each Appellant. Based upon this memo, Appellants argue that the Department and DDSN participated in ex parte communication regarding each Appellant's case, and thus, it is impossible to receive a hearing before an unbiased tribunal. I disagree. Pursuant to S.C. Code Ann. § 1-23-360, employees of an agency, authorized to determine decisions in a contested case, may not communicate with a party unless notice and an opportunity is given to all parties to participate in such communication:

> Unless required for the disposition of ex parte matters authorized by law, members or employees of an agency assigned to render a decision or to make findings of fact and conclusions of law in a contested case shall not communicate, directly or indirectly, in connection with any issue of fact, with any person or party, nor, in connection with any issue of law, with any party or his representative, except upon notice and opportunity for all parties to participate. An agency member:
> (1) May communicate with other members of the agency; and
> (2) May have the aid and advice of one or more personal assistants.

The individuals named in the memo do not perform any adjudicatory functions with regard to the cases before the Department. In fact, the Department's Director of the Division of Appeals and Hearings is responsible for assigning cases to be heard by the Department's hearing officers. The Department's hearing officers are responsible for "making findings of fact and conclusions of law," and no hearing officer was included in the February 18, 2010 communication. Furthermore, pursuant to section 1-23-360, agency members may participate in permissible communication with other members of the agency. The Department and DDSN are separate agencies, but as discussed above, these agencies work together as the Department administers and manages the state's Medicaid

programs and DDSN is responsible for the state's treatment and training programs for people with mental retardation and related disabilities. Moreover, even if the February 18, 2010 memo could be construed as impermissible ex parte communication, Appellants have not shown how the memo resulted in prejudice against each Appellant. See Ross v. MUSC, 328 S.C. 51, 492 S.E.2d 62 (1997) (discussing that when determining whether ex parte communication by an administrative agency warrants reversal of the agency's decision, the court does not follow a per se rule automatically reversing the agency decision; rather, the court considers whether prejudice resulted from the ex parte communication).

Appellant Edge also argues that the Department participated in ex parte communication with regard to her case. Specifically, Appellant argues that the Department's Director of the Division of Appeals and Hearing personally contacted Edge's mother by phone after Edge's counsel filed her appeal with the Department. The Department's Director did contact Edge's mother by phone; however, the record reflects that a second appeal to the Department was filed by Edge's parents. The Department's Director contacted Edge's mother to clarify Edge's representation before the Department's hearing. Once Edge's mother confirmed that counsel would be representing Edge in any appeal before the Department, no further communication occurred between the Director and Edge's mother. Thus, the Director did not engage in ex parte communication with Appellant or any member of her family. Furthermore, Appellant has not shown how she was prejudiced by such communication. See Ross v. MUSC, 328 S.C. 51, 492 S.E.2d 62.

ii. Incomplete Record

Appellants next argue that they are unable to receive a fair hearing before an unbiased Department hearing officer based upon intentional acts of misconduct. Specifically, Appellants argue that the Department intentionally omitted certain documents from the record in an attempt to cause Appellants to miss the deadline to appeal to the ALC. While some documents were omitted from the record in this matter, all documents omitted are now a part of the record. There is nothing in the record – and Appellants do not provide any credible evidence – to suggest that the omission of the documents was an intentional act of the Department. Moreover, Appellants do not cite any legal authority to support their allegations. Glasscock, Inc. v. U.S. Fidelity and Guar. Co., 348 S.C. 76, 81, 557 S.E.2d 689, 691 (Ct. App. 2001) ("[S]hort, conclusory statements made without supporting authority are deemed abandoned on appeal and therefore not presented for review.").

iii. Other Judicial Forums

Finally, Appellants argue that they are unable to receive a fair hearing before an unbiased Department hearing officer as shown by the fact that the Department argued in other judicial forums Appellants' cases should be dismissed so that the cases can be litigated in the state administrative appeals process while simultaneously arguing before the ALC that the appeals before the ALC should be dismissed. Appellants do not provide any credible evidence or point to any reference in the record to substantiate this allegation. Moreover, Appellants do not cite any legal authority to support their allegations. Glasscock, Inc., 348 S.C. at 81, 557 S.E.2d at 691.

C. Fair Hearing

Appellants primarily argue that their due process rights have been violated by the Department because it failed to provide adequate notice and an evidentiary hearing and a final decision within ninety days of Appellants' requests for fair hearings.

i. Notice

Appellants appear to challenge the Department's failure to provide adequate written notice of the reduction in services pursuant to the waiver renewal as required under 42 C.F.R. 431.210. However, I find this ground on appeal has not been preserved for appellate review. Appellants refer to this alleged violation within the "Facts" section of the brief. Appellants do not include this issue as a separate ground on appeal and there is no reference or citation to any legal authority contained within the discussion section of their brief. Thus, I conclude that this ground on appeal has been abandoned. Glasscock, Inc., 348 S.C. at 81, 557 S.E.2d at 691.

ii. Opportunity for a Fair Hearing

The procedures for appealing a decision regarding Medicaid services provided under the MR/RD waiver program are set forth in the Code of Federal Regulations. See 42 C.F.R. §§ 441.200 et. seq. Those regulations provide that a state-level hearing for Medicaid recipients under a state waiver "must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970)." 42 C.F.R. § 431.205(d). The state agency must grant an opportunity for a hearing to any applicant who requests it because his claim for services is denied, 42 C.F.R. § 431.220(a)(1), or if the state agency takes action to suspend, terminate or reduce services. 42 C.F.R. § 431.200(b). However, the agency is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients. 42 C.F.R. § 431.220(b). As a state

agency administering the Medicaid program, the Department must comply with all federal Medicaid laws and regulations. Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007).

The Department presents two arguments in support of the dismissals of Appellants' cases without hearings: 1) the Department argues that the reduction of benefits imposed on Appellants pursuant to the revised waiver is an issue involving a change in state or federal law; thus, no hearing is required pursuant to 42 C.F.R. § 431.220(b) (stating that the agency need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients); and 2) the Department argues that the administrative process afforded to Appellants met the requirements of due process and the federal regulations because the Department offered Appellant an opportunity to present written arguments in response to the interlocutory order.

I disagree with the Department's argument that the revised waiver is an issue involving a change in state or federal law, and thus, no hearing is required pursuant to 42 C.F.R. § 431.220(b). As discussed above, South Carolina must seek approval for waiver programs from the CMS. However, CMS' approval of the waiver does not have the force and effect of law because the waiver reduction was not promulgated as a regulation. While South Carolina has not directly addressed this question, other states have concluded that the provisions of a waiver document must be promulgated as regulations under the state's APA in order to be enforceable as a rule or binding norm. See McCrann v. N.C. Dept. Health and Human Services, 704 S.E.2d 899 (N.C. App. 2011) (holding that it was error of law for the agency to rely upon the provisions of a waiver to deny services to a Medicare beneficiary, and that the provisions of the waiver limiting benefits were "rules" that must be promulgated as regulations pursuant to the state APA in order to carry the force of law); Hoban v. State of Vermont, Op. No. 200-4-05, Lexis 40 (Vt. Super. 2005) (holding that a cap on HCBS contained in a Medicaid waiver program was void due to the agency's failure to promulgate the cap as a regulation under the state APA); Mullins v. N. Dakota Dept. of Human Services, 454 N.W.2d 732 (N.D. 1990) (invalidating unpromulgated manual provisions claiming to define individuals eligible for benefits). Thus, Appellants' cases do not fall within the exception contained in 42 C.F.R. § 431.220(b).

The Department next asserts that because Appellants failed to adequately respond to the interlocutory orders issued by the hearing officers "with an allegation of error in fact or in law,"

Appellants failed to avail themselves of the opportunity the Department offered for a hearing. The Department cites Zaman v. South Carolina State Board of Medical Examiners, 305 S.C. 281, 285, 408 S.E.2d 213, 215 (1991) to support its argument that Appellants "cannot complain of a due process violation if [they have] recourse to constitutionally sufficient administrative procedure but merely decline[] or fail[] to take advantage of it." The Department further asserts that pursuant to Rosen v. Goetz, 410 F.3d 191 (6th Cir. 2005), only an opportunity for a written argument is minimally required in some cases, such as Appellants'. A prior Administrative Law Court decision has addressed this issue, and this Court agrees with its determination. See Hickey v. S.C. Dep't of Health and Human Svcs., (10-ALJ-08-0656-AP, J. Durden (July 19, 2011)). As discussed in Hickey, the Rosen case arose in a different context. Like Hickey, I find the hearing requirements applicable to this case to be controlled by the federal regulations and the standard enunciated by the Supreme Court in Goldberg v. Kelly, 397 U.S. 254, 268-269, 90 S. Ct. 1011, 1021, 25 L. Ed.2d 287 (1970). The Goldberg Court held:

> The city's procedures presently do not permit recipients to appear personally with or without counsel before the official who finally determines continued eligibility. Thus a recipient is not permitted to present evidence to that official orally, or to confront or cross-examine adverse witnesses. These omissions are fatal to the constitutional adequacy of the procedures. The opportunity to be heard must be tailored to the capacities and circumstances of those who are to be heard. It is not enough that a welfare recipient may present his position to the decision maker in writing or second-hand through his caseworker. Written submissions are an unrealistic option for most recipients, who lack the educational attainment necessary to write effectively and who cannot obtain professional assistance. Moreover, written submissions do not afford the flexibility of oral presentations; they do not permit the recipient to mold his argument to the issues the decision maker appears to regard as important....Therefore a recipient must be allowed to state his position orally.

The controlling federal regulations specifically require the Department to "meet the due process standards set forth in Goldberg." 42 C.F.R. § 431.205(d). Moreover, federal regulations require the Department to grant an opportunity for a hearing to any applicant who requests it because his claim for services is denied, 42 C.F.R. § 431.220(a)(1), or if the state agency takes action to suspend, terminate or reduce services. 42 C.F.R. § 431.200(b). Because the Department seeks to reduce Appellants' benefits and each requested an individual hearing, it was error for the Department to deny hearings to the Appellants on the basis of Appellants' failure to state a claim upon which relief can be granted. Evans v. State Retirement, 344 S.C. 60, 543 S.E.2d 547 (2001) ("As a general rule,

important questions of novel impression should not be decided on a . . . motion to dismiss. Instead, a novel issue is best decided in light of the testimony to be adduced at trial. However, where the dispute is not as to the underlying facts but as to interpretation of the law, and development of the record will not aid in the resolution of the issues, it is proper to decide even novel issues on a motion to dismiss for failure to state a claim." (citations omitted)).

ORDER

For the reasons set forth above,

IT IS HEREBY ORDERED that the Department's decisions to reduce and/or terminate Appellants' services and/or supplies are **REVERSED**.

IT IS FURTHER ORDERED that before taking any further action regarding Appellants' benefits under the MR/RD waiver, the Department must provide each Appellant with an evidentiary hearing consistent with the reasoning set forth above, within 60 days from the date of this Order.

AND IT IS SO ORDERED.

SHIRLEY C. ROBINSON
Administrative Law Judge

November 14, 2011
Columbia, South Carolina

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above captioned action upon all parties to this cause by depositing a copy thereof, in the United States mail, postage paid, in an envelope addressed to the party's or their attorney(s).
This 9 day of November 2011
By: Jeanette Henderson
Judge's Law Clerk

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South Carolina Department of Health & Human Services

Anthony G. Keck, Director
Nikki R. Haley, Governor

APPEALS & HEARINGS
RECEIVED
DEC 14 2011
SCDHHS

December 14, 2011

Robert French, Hearing Officer
Division of Appeals & Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Re: Scheduled Hearings in Morgan (1/3/12), Eubanks (1/4/12), Edge (1/5/12), and Myers (1/6/12)

Dear Mr. French:

This is in return to Ms. Harrison's request that the above referenced hearings be canceled. First of all, we believe that Ms. Harrison has incorrectly interpreted the *Hickey* Order (attached). We believe that the Order does not mean that the reductions are invalid, but only means that the reductions contained in the 1/1/2010 Waiver renewal cannot be treated as a binding norm or used as the sole legal reason to uphold a particular reduction. In other words, the Department must provide an opportunity for an evidentiary hearing on the factual basis for a proposed reduction in each case.

Having said that, Because of the pendency of a federal district case in which Morgan and Eubanks (above) are involved, the Department will not impose the proposed reduction on these two (2) cases and we believe that Ms. Harrison is correct that those hearings should be canceled. Thus, with respect to these two (2) cases, Judge Robinson's Order (also attached) is satisfied, because no further action will be taken at this time with respect to those individuals. Waiver participants are subject to regular review, but any future action would require an opportunity for an evidentiary hearing on the factual basis for the action.

Furthermore, because of the very minimal difference in the Edge pre-Waiver revision authorization (32 cases per year), the Department does not intend to impose a 24-case annual limit on nutritional supplements provided to this Petitioner in accordance with the revised limits in the Waiver. In accordance with this case also, we believe Judge Robinson's Order to be satisfied.

However, the Department does intend to go forward with its proposed further action in the case of Myers. The Department does intend to impose the previously asserted reductions, in accordance with the Waiver limits. Therefore, the Department's position is that hearing should proceed as scheduled. We believe that Judge Robinson's Order presumes that by now, the Petitioners are fully aware of the actions being taken and the basis for the actions. To restate:

Meyers: The Department intends to impose limit of 28 weekly hours of Personal Care Aide II services, in accordance with the Waiver limits, set in accordance with 42 CFR §440.180(b). The Department also intends to impose a limit of 24 weekly 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.

Therefore we believe that the hearing in Myers should proceed as planned, subject to any scheduling exigencies. Please contact me if you need additional information or anything else is required.

RESPONDENT'S EXHIBIT

Sincerely,

Richard G. Hepfer
Deputy General Counsel

Enclosure

cc: Ms. Patricia Harrison, Attorney for the Petitioners

Office of General Counsel
P. O. Box 8206 Columbia South Carolina 29202-8206
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Received BKS 12-19-11

South Carolina Department of
Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

December 29, 2011

Ms. Betsy Schindler, Hearing Officer
Division of Appeals and Hearings
SC Dept. of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Re: Mr. Albert Cooper Myers v. DHHS Case #11-MISC-302 (MR/RD)

Dear Ms. Schindler:

Enclosed for your consideration, is the Department's Prehearing Brief in this matter. Please take this letter as my notice of appearance in this matter and my certification that a true and correct copy of this Brief has been sent to **Ms. Patricia Harrison, Law Offices of Patricia L. Harrison, 611 Holly Street, Columbia, SC 29205.**

If there are questions, please do not hesitate to contact me. My direct line is (803) 898-2791.

Sincerely,

Richard G. Hepfer
Deputy General Counsel

Enclosure

cc: Ms. Patricia Harrison

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RESPONDENT'S
EXHIBIT
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STATE OF SOUTH CAROLINA COUNTY OF RICHLAND	)	BEFORE THE APEALS DIVISION OF THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES
Mr. Albert Cooper Myers, Petitioner, -v- State Department of Health and Human Services, Respondent.	)	PREHEARING BREIF 11-MISC-302 (MR/RD)

TO: Ms. Betsy Schindler, Hearing Officer, Division of Appeals and Hearings, South Carolina State Department of Health and Human Services, Post Office Box 8206, Columbia, SC 29202-8206 AND Ms. Patricia Harrison, Law Office of Patricia L. Harrison, 611 Holly Street, Columbia, SC 29205

Background

The Petitioner in this matter is a Medicaid-eligible individual, who has been receiving services under the South Carolina Mental Retardation/Related Disabilities (MR/RD) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through the Department of Disabilities and Special Needs (DDSN). Waivers are mechanisms within the Medicaid Program under which by "waiving" certain generic requirements of the Medicaid program States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. This and other Waivers operated by DDSN are for home and community based services under Section 1915(c) of the Social Security Act [42 USC §1396n(c)]. These types of Waivers allow services to be provided in the home, in lieu of institutional services.

On January 1, 2010, the five-year renewal of the MR/RD Waiver, as approved by the Centers for Medicare and Medicaid Services (CMS), went into effect. The renewed Waiver included a cap or limit on some services and elimination of others. The DDSN is responsible for the day-to-day operation of this Waiver. The Department of Health and Human Services (Department, DHHS,

2. Personal care Aide II services were limited to 28 hours per week.
3. Respite Care was limited to 68 in home hours per month, however an exception allowed up to 240 in home hours based on the criteria described below, in the definition of the service on page 5.

   (During the pendency of the appeal, the Petitioner continued to receive PT, 101 monthly hours of Respite care, and 45 weekly hours of PCAII services. The other services were initially unchanged.)
4. On or about January 12, 2011, the Petitioner was authorized 6 hours per week of Personal Care Aide I services.
5. Following the 2011 Plan of Service meeting, the Petitioner was authorized psychological counseling.

The Petitioner sought a Reconsideration of the eliminations or reductions. However, on January 13, 2010, the Director of DDSN upheld the changes. The Petitioner appealed to the DHHS Appeals Division on February 11, 2010. On February 25, 2010, the assigned Hearing Officer issued an Interlocutory Order asking that the Petitioner specify errors in the Department's decisions to reduce or eliminate services in accordance with the new Waiver. On or about March 15, 2010, the Petitioner Responded through counsel (Page 24 of the Record on Appeal to the Administrative Law Court [ALC]) and the Respondent countered through counsel (Page 12 of the Record). The Hearing Officer dismissed the matter (page 2 of the Record). At the ALC, the matter was consolidated with other similar matters, and, on November 9, 2011, Judge Robinson remanded the matter to the Department for an evidentiary hearing, finding that it was error to dismiss the matter without an evidentiary hearing.

Thus the matter is back before the Appeals Division as a contested case. The Administrative Law Judge in this matter has ruled that, in this case, the Supreme Court case of Goldberg v. Kelly, 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed. 2d 287 (1970) controls and the Petitioner should be afforded an evidentiary hearing. Furthermore, in this case, the Hearing Officer may not treat the reductions and limitations in the Waiver document as "binding norms," or matters of federal of state law.

Respondent) is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the waiver. Appeals of DDSN determinations are to the Appeals and Hearings Divisions of the DHHS.

The Petitioner in this case is developmentally disabled, suffering from Atheloid Cerebral Palsy, Arthrogroposis and Scoliosis. Due to lack of ability to swallow properly, he must take food and medications through a tube and, recently, there has been concern about skin breakdown.

Procedural Posture

This case originally started as a Request for Reconsideration to the Director of the Department of Disabilities and Special Needs. The Petitioner was asking for reconsideration of the imposition of the limitations set forth in the January 1, 2010 renewal of the Home and Community Based Waiver # SC.0237.R04.00, known federally as the Mental Retardation and Related Disabilities Waiver. (The State terminology has changed to: Intellectual Disability and Related Disabilities or ID/RD Waiver.) As of the effective date of the Waiver limitations (1/1/2010) the Petitioner was receiving the following services:

1. Dental Services
2. Physical Therapy: 4 units, or 1 hour per week
3. Personal Care Aide II: 180 units or 45 hours per week
4. Routine and emergency medical care
5. Community Services: 5 units per week (This would be conducted during ½ of the day consisting of the time between 8:30 am and 2:30 pm.)
6. Respite care: 456 hourly units and 48 days per year
7. Speech Therapy was not being provided
8. Medical supplies, such as diapers and pads were being provided
9. Day Services were being provided -- 5 units (again ½ of the day, as described above) per week.

The January 1, 2011, Waiver changes eliminated, limited, or otherwise changed the following services that were being received by the Petitioner:

1. Physical therapy services were eliminated

Arguments

1) An adequate array of services is available to the Petitioner:

Physical Therapy:

The January 1, 2010 Waiver Renewal eliminated Physical Therapy (PT) as a Waiver service. PT is still available as a State Plan Service to adults, in accordance with the following guidelines as set forth in the Physicians Manual at page 2-145:

> For adults over 21 years of age, reimbursement is allowed for physical, occupational, and speech therapies performed under the following guidelines. The patient's record must substantiate at least **ONE** of the following requirements for therapy:
>
> - The attending physician prescribes therapy in the plan of treatment during an inpatient hospital stay and therapy continues on an outpatient basis until that plan of treatment is concluded.
> - The attending physician prescribes therapy as a direct result of outpatient surgery.
> - The attending physician prescribes therapy to avoid an inpatient hospital admission.

During the pendency of the appeal, the Petitioner's continued to receive PT services. As set forth above, physical, occupational and speech therapy are available to adults as specified, and particularly in this case if the Petitioner's attending physician prescribed the therapy to avoid hospitalization.

Personal Care:

Personal care-type services can be provided by a personal care aide or a respite caregiver. The descriptions of Personal Care Aide II and Personal Care Aide I services are set forth in the Waiver document:

> Active, hands-on assistance in the performance of Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) provided to the waiver participant in his/her home. This service may only be provided in other locations when defined in the Plan of Service. ADLs include assistance with eating, bathing, dressing, toileting, transferring, maintaining continence, and assistance with ambulation. If it is determined that a participant requires more than one personal care aide, this must be prior approved by SCDDSN and documented on the Plan of Service. IADLs include light housework, laundry, meal preparation and shopping. These IADL activities are for the specific needs of the participant, not the general needs of the household. IADLs may also include home safety, assistance with communication, medication monitoring to include informing the participant that it is time to take medication prescribed by his/her physician or handing the participant a medication container, and limited assistance with financial matters such as delivering payments as directed by the participant on his/her behalf. Personal Care 2 services may include escort and transportation when necessary. This must be specifically

documented in the Plan of Service; there must be no other resources available and the provision of transportation will depend upon the personal care provider's policy in this regard. Personal care services can be provided on a continuing basis or on episodic occasions. Under no circumstances will any type of skilled medical service be performed by an aide except as allowed by the Nurse Practice Act and prior approved by a licensed physician. Authorizations to providers will be made at two different payment levels. Based on SCDDSN assessed need, the higher level service, Personal Care 2 (PC2), may be considered appropriate when the care needed is for assistance with ADLs alone or in conjunction with assistance with IADLs/home support. Based on SCDDSN assessed need, the lower level service, Personal Care 1 (PC1), may be considered appropriate when the only needed care is for IADLs/home support activities. PC1 does not include hands-on care. Unless prior-approved, 2 aides may not be authorized for service delivery at the same time.
Specify applicable (if any) limits on the amount frequency or duration of this service:
Personal Care 2 (PC2): Up to 112 units (28 hours) per week as determined by SCDDSN assessment. A unit is defined as 15 minutes of service provided by one aide. When PC2 is authorized in conjunction with Adult Attendant and/or Adult Companion, the combined total hours per week of all of those services may not exceed 28 hours per week. Personal Care 1 (PC1): Up to 24 units (6 hours) per week as determined by SCDDSN assessment. A unit is defined as 15 minutes of service provided by one aide.

Essentially, PCAIs perform the Instrumental Activities of Daily Living (IADLs) and the PCAIIs perform the basic Activities of Daily Living (ADLs). These are hands on services and are not intended to be approved for only observing and monitoring an individual. In addition, "Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide." Page 1 of the Waiver document.

The Description of Respite care is also set forth in the Waiver document:

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care will be provided in the following location(s):
Individual's home or place of residence, or other residence selected by the recipient/representative.
Foster home
Medicaid certified ICF/MR
Group home
Licensed respite care facility
Other community care residential facility approved by the State that is not a private residence (Specify type): Community
Residential Care Facility
Licensed Nursing Facility (NF)
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Limit up to 68 hours of in-home respite/month as determined by SCDDSN assessment. In-home respite is provided outside of a Medicaid certified ICF/MR or Medicaid NF. An exception of up to 240 units per month (56 hours/week) of in-home respite may be authorized due to the following special need circumstances: 1) the caregiver's hospitalization or need for medical treatment; 2) the participant's need for constant hands-on/direct care and supervision due to a medically complex condition or severity/degree of disability; or 3) sensonal relief for those over age 12 who attend

public school and whose parents work full time and care is needed during summer break from school. These exceptions must be approved by SCDDSN.

For PCAII services and Respite services, the qualifications of the providers are comparable. Both types of providers must be able to aid an individual with ADLs, follow a plan of care, and demonstrate competency in their area of work. As stated above, the Petitioner was authorized for 6 hours per week of Personal Care Aide I services in order to deal with some of the IADLs as described in the Definition, above. However, not counting PCAI services, the Petitioner would still receive 28 weekly hours of PCAII services and whatever amount could be justified according to the Respite care exception policy. This is not necessarily a reduction in care, but only a reconfiguration of the mix of services provided.

Day Services:

In addition, the Petitioner still was authorized to receive day services, for most of the main part of the day. These services are described in the Waiver document:

Community Support Services:

> Services aimed at developing one's awareness of, interaction with and/or participation in their community through exposure to and experience in the community and through teaching such concepts as self-determination, self-advocacy, socialization and the accrual of social capital. Services will be provided in facilities licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Community Services. On site attendance at the licensed facility is not required to receive services that originate from the facility. Payment for Community Services can not include the cost of room and board.
>
> Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participant's habilitation site to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

There are no limits on this service, but it is not offered on the weekend.

Day Activity Services

> Supports and services provided in therapeutic settings to enable participants to achieve, maintain, improve, or decelerate the loss of personal care, social or adaptive skills. Services are provided in non-residential settings that are licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Day Activity. On site attendance at the licensed facility is not required to receive services that originate from the facility

> Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participant's habilitation site to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

There are no limits on this service, but again, it is not offered on the weekend. However, the staff at the Day Service provider (Community Support and Day Activity) was able to administer the Petitioner's tube feeding for the midday meal.

In August of 2011, the Petitioner elected to switch services from Community Support Services (1/2 day) and Day Activity Services (1/2 day) to a full day of Adult Day Heath Care (ADHC) Service, which is described below.

> Services furnished 5 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both heath and social services needed to ensure the optimal functions of the individual. The State intends to limit services to individuals with medically complex conditions, or individuals who require extensive assistance with functional activities/tasks as determined by SCDDSN assessment. Authorization of services will be based on the participant's need for the service as identified and documented in his/her plan of care. Meals provided as part of this service shall not constitute a full nutritional regime (3 meals per day). Physical, occupational and speech therapies indicated in the participant's plan of care are not furnished as component parts of this service.

There are no limits specified, but the service is not available during the weekends. In this setting, the Petitioner was also able to receive a tube feeding as well as nursing services.

2) These services are sufficient in amount duration and scope, and also adequate for the Petitioner to be maintained in the community.

Sufficient

In the case of home and community based waivers services, the specific services may be set in accordance with 42 CFR §440.180 of the Medicaid Regulations:

> 440.180 Home or community-based services.
>
> (a) Description and requirements for services. "Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

(1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by CMS.
..... (emphasis added)

"CMS" is the abbreviation for the Centers for Medicare and Medicaid Services, the federal agency that administers the Medicaid Program. Also, in accordance with the regulations, at 42 CFR §440.230, sufficiency of amount, duration, and scope of services is to be as follows:

(a) The plan must specify the amount, duration, and scope of each service that it provides for--
(1) The categorically needy; and
(2) Each covered group of medically needy.
(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under Sec. Sec. 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

This section has recently been interpreted by a few courts, for example, in the case of Freeman v. State of Washington Department of Social and Health Services, 2010 WL 3720285 (W.D. Wash, Sept. 17, 2010). In that case Plaintiffs raised the issue of inadequacy under §440.230(b) brought about by a general, statewide, reduction in Personal Care Aide Services, one of the services being provided to the Petitioner. In deciding that the Plaintiffs could not show that the reduction violated the standard, the court referenced the earlier case of Alexander v. Choate, 469 U.S. 287, 105 S. Ct. 712, 83 L.Ed.2d 661 (1985). In that case the Supreme Court said:

> [M]edicaid programs do not guarantee that each recipient will receive the level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services... That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered-not "adequate health care."

Freeman, at 11.

In this case, the Departments have, with the approval of CMS, specified the package of services to be available to Waiver participants. Although the services are extensive, and will meet the needs of most participants, it is not required under §440.230 that the Petitioner's needs are completely or precisely met.

Adequate to Maintain in the Community

However, under Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999), States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. Olmstead, at 587. However, "[t]he State's responsibility once it provides community-based treatment to qualified persons with disabilities is not boundless," Olmstead at 603.

In the Olmstead case, the Court was considering the Justice Department's regulations and general approach in enforcing the ADA. It found that courts must consider the totality of the expenses and programs undertaken by the State when evaluating the fundamental alteration defense. More generally, the States retain the right, as explained in the implementing regulations not to "take any action that [they] can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens." 28 C.F.R. § 35.150(a)(3). The concept of "fundamental alteration is further explained, in part, below:

> Sec. 35.130 General prohibitions against discrimination.
>
> (a) No qualified individual with a disability shall, on the basis of 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 public entity.
>
> (b)
>
> .....
>
> (7) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

"Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities." Olmstead, at 604.

In evaluating a fundamental-alteration defense, the [court] must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably. Olmstead, at 597.

Thus the courts have acknowledged the fundamental alteration defense in applying the rules in Olmstead. In this case the Departments had recently applied for renewal of the MR/RD Waiver, which has been approved by CMS. The DDSN has responsibility for providing services to the developmentally disabled population of the State. In order to equitably apportion services, the Department must be allowed to reasonably limit otherwise "boundless" services.

Conclusion

During his time in the community, the Petitioner received between thirteen and fourteen hours per day of supervision and care by caregivers provided through the Waiver. Prior to April of 2011, most of the care was provided by a live-in personal care aide who also provided respite care. In April, the live-in caregiver was injured while trying to lift the Petitioner using the existing mechanical lift. The lift was replaced. However, the paid live-in caregiver has not been able to return, and this has necessitated a change in providers which has not always worked out due to missed appointments and changes in personnel. After the live-in caregiver was injured, the Petitioner began to receive psychological counseling for some depression due to the loss of the known caregiver. In December of 2011, the Petitioner was admitted to a long term care facility.

Nevertheless, the Respondent's position is that, with the mix of services available even under the new Waiver limits, the Petitioner could be maintained in the community as well or better than prior to the change in Waiver services. If he could not be maintained with the existing services, to augment those services beyond the Waiver limits would constitute a fundamental alteration in the nature of the program.

Therefore, the Respondent requests that the Hearing Officer inquire into the matter, and issue a Decision.

1. Finding that sufficient services are available under the new Waiver limits in order to maintain the Petitioner in the community; and
2. Granting such other remedies as justice should demand.

Respectfully Submitted,

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Attorney for the Respondent

Columbia, South Carolina
December 29, 2011

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
Due to the State of South Carolina's budget situation, SCDDSN opted to make minor adjustments to the MR/RD waiver program. SCDHHS and SCDDSN worked together for many months to consider possible changes administratively allowed within federal regulations. To obtain public input, SCDDSN conducted a survey of waiver participants, parents and other interested stakeholders. Additionally, staff from both agencies hosted a well-attended public meeting. The information gained guided SCDDSN toward making necessary budgetary adjustments including the following:

Services for which limits will be implemented:
- Specialized Medical Equipment, Supplies and Assistive Technology:
a) lower the monthly limit of liquid nutrition (for those without a feeding tube) to 2 cases per month;
b) limit the cost per wheel chair to $8,000 total and allow only 1 chair every 5 years;
- Nursing: limit services up to 56 hours per week for LPN or 42 hours per week for RN;
- In-home Respite: limit services up to 68 hours per month;
- Personal Care 2: limit services up to 28 hours per week. (Note: The participant is limited to a combined total of 28 hours per week for PC2, Adult Companion and/or Adult Attendant);
- Personal Care 1: limit service to 6 hours per week;
- Adult Companion Care: limit services up to 28 hours per week. (Note: participant is limited to a combined total of 28 hours of companion, PC2 and/or attendant care per week);
- Adult Attendant Care: limit services up to 28 hours per week. (Note: participant is limited to a combined total of 28 hours of companion, PC2 and/or attendant care per week).

Services to be removed:
Physical Therapy
Occupational Therapy
Speech Language pathology
Day Habilitation (replaced with Day Activity)
Supported Employment (replaced with Employment Services)
Prevocational Habilitation (replaced with Career Preparation)

Service to be added:
Personal Emergency Response System (previously covered under Specialized Medical Equipment)

RESPONDENT'S EXHIBIT

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment, Supplies and Assistive Technology

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition *(Scope):*

Specialized medical equipment, supplies and assistive technology to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. This service may include consultation and assessment to determine the specific needs related to the individual's disability for which specialized medical equipment and assistive technology will assist the individual to function more independently. Consultation and assessment cannot be used to determine the need for supplies.

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

The limit is 3 cases per month of diapers and 3 cases per month of under pads.

The limit is 2 cases per month of liquid nutrition for waiver participants without a feeding tube. Liquid nutrition for waiver participants on a feeding tube is provided by Medicaid State Plan and is not covered by the waiver.

Cost per wheelchair is limited to a maximum of $8000 per chair and a maximum of 1 chair every 5 years if medically justified.

Service Delivery Method *(check each that applies):*

- **Participant-directed as specified in Appendix E**
- **Provider managed**

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

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DSN Board/contracted providers
Individual	Independent Environmental Access Consultants/contractors
Agency	Technicians or professionals certified in the installation and repair of manufacturers equipment
Individual	Technicians or professionals certified in the installation and repair of manufacturer's equipment
Individual	Licensed Occupational or Physical Therapists

PC (Revised 3-1-11)

Personal Care Services (age 21 and over)

(Refer to the Miscellaneous chapter of this manual for those under age 21)

Definition: Active, hands-on assistance in the performance of Activities of Daily Living (ADL's) or Instrumental Activities of Daily Living (IADL's) provided to the waiver participant in his/her home. This service may only be provided in other locations when defined in the Support Plan. ADL's include assistance with eating, bathing, dressing, toileting, transferring, maintaining continence, and assistance with ambulation. If it is determined that a participant requires more than one personal care aide, this must be prior-approved by DDSN and documented on the Support Plan. IADL's include light housework, laundry, meal preparation and shopping. These IADL activities are for the specific needs of the participant, not the general needs of the household. IADL's may also include home safety, assistance with communication, medication monitoring – to include informing the participant that it is time to take medication prescribed by his/her physician or handing the participant a medication container – and limited assistance with financial matters, such as delivery of payments as directed by the participant on his/her behalf.

Authorizations to providers will be made at two different payment levels. Based on DDSN assessed need, the higher level service, Personal Care 2, may be considered appropriate when the care needed for assistance with ADL's alone or in conjunction with assistance with IADL's/home support. Based on DDSN assessed need, the lower level service, Personal Care 1, may be considered appropriate if the only needed care is for IADL's/home support activities. PC 1 does not include hands-on care.

Personal Care 2 services may include escort and transportation when necessary. This must be specifically documented on the Support Plan; there must be no other resources available; and, the provision of transportation will depend upon the personal care provider's policy in this regard.

Personal Care services can be provided on a continuing basis or on episodic occasions. Under no circumstances will any type of skilled medical service be performed by an aide except as allowed by the Nurse Practice Act and prior-approved by a licensed physician. The Nurse Practice Act is available on the following web page: http://www.scstatehouse.gov/code/t40c033.htm

Both services allow the provider to accompany the participant on visits in the community when the visits are related to the needs of the participant, specified in the Support Plan, and related to needs for food, personal hygiene, household supplies, pharmacy or durable medical equipment. The Service Coordinator has the responsibility to identify the necessity of the trip, document the need in the Support Plan, authorize this component of the service, and monitor the provision of the services.

The unit of service is 15 minutes, provided by one Personal Care Aide (PCA).

Please see: Scope of Services for Personal Care 1 (PC 1) Services
Scope of Services for Personal Care 2 (PC 2) Services

Service Limits: Personal Care 2 Services are limited to a maximum of 28 hours (112 units) per week, as determined by SCDDSN assessment. A week is defined as Sunday through Saturday. When Personal Care 2 is authorized in conjunction with Adult Attendant Care and/or Adult Companion Services, the combined total hours per week of services may not exceed 28. Unused units from one week cannot be banked (i.e. held in reserve) for use during a later week.

Personal Care 1 Services are limited to a maximum of 6 hours (24 units) per week, as determined by SCDDSN assessment.

RESPONDENT'S EXHIBIT 6 554

Participants receiving Residential Habilitation may not receive Personal Care (1 or 2) Services through the MR/RD Waiver.

Providers: Personal Care Services must be provided to participants by an agency contracted with the Department of Health and Human Services. The recipient/family should be given a listing of available providers from which to choose. **The offering of this provider choice must be documented**

Agencies contracted with the Department of Health and Human Services must adhere to the requirements noted in the Scope of Services for Personal Care Services (1 and 2) for the MR/RD Waiver, which specifies the minimum qualifications for a PCA 1 and for a PCA 2.

Arranging for and Authorizing Services: The need for the service must be documented in the participant's Support Plan. To assess the need for Personal Care Services, the Service Coordinator must complete the Personal Care/Attendant Care Assessment for Adults (MR/RD Form 34). The Support Plan must also include documentation of the amount, frequency, duration and provider type of the service. Personal Care Services (1 or 2) are approved at the local level.

The participant/family should be given a listing of available providers from which to choose. This offering of provider choice must be documented. Once the service is approved and an agency is selected, the Service Coordinator should complete the Authorization for Personal Care Services (MR/RD Form A-3) and send a copy to the chosen agency. This authorization remains in effect until a new/revised Authorization for Personal Care Services (MR/RD Form A-3) is sent or until services are terminated (see Chapter 8).

Monitoring Services: The Service Coordinator must monitor the service for effectiveness, usefulness and participant satisfaction. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following guidelines should be followed when monitoring Personal Care Services (1 and 2):

- During the first month of service, monitoring should be conducted while the service is being provided, unless the Service Coordination Supervisor documents an exception. An exception can only be made when the service is provided in the late evening or early morning hours (between 9:00 pm and 7:00 am).
- Services should be monitored at least once during the second month of service.
- Services should be monitored at least quarterly (i.e. within 3 months of the previous monitoring) thereafter.
- The monitoring schedule must start over any time there is a change of personal care provider.
- Monitoring should be conducted on-site at least once annually (i.e. within 365 days of the previous on-site monitoring).
- Monitoring must be conducted by contact with the participant/family. It can be supplemented with contact with the service provider.
- Review the daily logs completed by the aides (Note: Daily logs can be requested from personal care providers as often as needed for monitoring purposes and must be requested for all on-site visits).
- Monitoring of the participant's health status should always be completed as a component of Personal Care monitoring.

Some questions to consider during monitoring include:

- Is the participant receiving Personal Care services as authorized?
- Does the PCA show up on time and stay the scheduled length of time?
- Does the provider show the participant courtesy and respect?

- Has the participant's health status changed since your last monitoring? If so, does the service need to continue at the level at which it has been authorized?
- Is the participant pleased with the service being provided, or is assistance needed in obtaining a new provider?
- What kinds of tasks is the PCA performing for the participant?
- If the PCA does not show up for a scheduled visit, who is providing back-up services?
- Who is providing supervision of the PCA? How often is on-site supervision taking place?

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
PERSONAL CARE/ATTENDANT CARE ASSESSMENT FOR ADULTS

WAIVER PARTICIPANT'S NAME: _____ DOB/AGE: _____ / _____

Service(s) Requested ☐ PC 1 ☐ PC 2 ☐ Attendant Care

I. PLEASE LIST ALL MEDICAL CONDITIONS AND WHEN EACH CONDITION FIRST OCCURRED. USE AN EXTRA SHEET OF PAPER IF YOU NEED MORE SPACE.

	DIAGNOSIS/MEDICAL CONDITION	DATE FIRST OCCURRED
1.		
2.		
3.		
4.		

II. LIST ALL PERSONS INCLUDING PAID SERVICE PROVIDERS (E.G., NURSES, RESPITE CARE, ETC) WHO ARE NOW HELPING CARE FOR THE PARTICIPANT. USE AN EXTRA SHEET OF PAPER IF MORE SPACE IS NEEDED.

PERSON/RELATIONSHIP	TIMES EACH DAY & DAYS EACH WEEK WHEN HELPING

III. PROVIDE A TWO WEEK SCHEDULE THAT SHOWS HOW/WHEN SERVICES/SUPPORTS (INCLUDING NATURAL SUPPORTS) ARE PROVIDED. INCLUDE THE ANTICIPATED SCHEDULE FOR PERSONAL CARE. USE AN EXTRA SHEET OF PAPER IF MORE SPACE IS NEEDED.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

ASSISTANCE NEEDED	ASSISTANCE REQUIRED	FREQUENCY, TIME REQUIRED, TIMES PER WEEK
A. PERSONAL CARE		
BATH: BED ☐ SHOWER/TUB ☐	PARTIAL ☐ TOTAL ☐	___X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
SHAVING:	PARTIAL ☐ TOTAL ☐	___X DAILY, 15 MIN ☐ OTHER ___, ___X WEEKLY
ORAL HYGIENE:	PARTIAL ☐ TOTAL ☐	___X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
SKIN CARE:	PARTIAL ☐ TOTAL ☐	___X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
DRESSING AND GROOMING:	PARTIAL ☐ TOTAL ☐	___X DAILY, 15 MIN ☐ OTHER ___, ___X WEEKLY
INCONTINENCE CARE:	PARTIAL ☐ TOTAL ☐	___X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
TOILETING:	PARTIAL ☐ TOTAL ☐	___X DAILY, 15 MIN ☐ OTHER ___, ___X WEEKLY
RE-POSITIONING/TURING IN BED:	PARTIAL ☐ TOTAL ☐	___X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
MONITORING MEDICATION:	PARTIAL ☐ TOTAL ☐	___X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY

(E.G., INFORMING THAT IT IS TIME TO TAKE MEDICATION AS PRESCRIBED OR AS INDICATED ON THE LABEL OR HANDING A MEDICATION CONTAINER – THE AIDE IS NOT RESPONSIBLE FOR GIVING MEDICATIONS).

MEDICAL MONITORING OF CONDITION - SPECIFY:

(E.G. MONITOR TEMPERATURE, CHECK PULSE RATE, OBSERVE RESPIRATORY RATE OR CHECK BLOOD PRESSURE)

_____	PARTIAL ☐ TOTAL ☐	FREQUENCY, TIME REQUIRED ___, ___X WEEKLY
_____	PARTIAL ☐ TOTAL ☐	FREQUENCY, TIME REQUIRED ___, ___X WEEKLY
EXERCISE:	PARTIAL ☐ TOTAL ☐	___X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
TRANSFERS:		
MANUAL ☐	PARTIAL ☐ TOTAL ☐	___X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
HOYER ☐	PARTIAL ☐ TOTAL ☐	___X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
SLIDING BOARD ☐	PARTIAL ☐ TOTAL ☐	___X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
LIFT SYSTEM ☐	PARTIAL ☐ TOTAL ☐	___X DAILY, 10 MIN ☐ OTHER ___, ___X WEEKLY
OTHER: _____	PARTIAL ☐ TOTAL ☐	___X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
OTHER PERSONAL CARE NEEDS:		
_____	PARTIAL ☐ TOTAL ☐	___X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
_____	PARTIAL ☐ TOTAL ☐	___X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY

ASSISTANCE/TIME NEEDED FOR PERSONAL CARE (TOTAL SECTION A): _____

B. MEAL AND DINING		
PREPARATION AND SET-UP:	PARTIAL ☐ TOTAL ☐	___X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
DINING/FEEDING:	PARTIAL ☐ TOTAL ☐	___X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY
CLEAN UP:	PARTIAL ☐ TOTAL ☐	___X DAILY, 30 MIN ☐ OTHER ___, ___X WEEKLY

ASSISTANCE/TIME NEEDED FOR MEALS/DINING (TOTAL SECTION B): _____

C. GENERAL/HOUSEHOLD		
FLOOR CLEANING PARTICIPANT'S ROOM/AREA:	PARTIAL ☐ TOTAL ☐	___X WEEKLY, 15 MIN ☐ OTHER ___
DUSTING PARTICIPANT'S ROOM/AREA:	PARTIAL ☐ TOTAL ☐	___X WEEKLY, 15 MIN ☐ OTHER ___
STRAIGHTENING PARTICIPANT'S ROOM/AREA:	PARTIAL ☐ TOTAL ☐	___X WEEKLY, 30 MIN ☐ OTHER ___

CHANGING BED LINENS:	PARTIAL ☐ TOTAL ☐	___ x WEEKLY, 15 MIN ☐ OTHER ___
PARTICIPANT'S LAUNDRY:	PARTIAL ☐ TOTAL ☐	___ x WEEKLY, 90 MIN ☐ OTHER ___
SHOPPING:	PARTIAL ☐ TOTAL ☐	___ x WEEKLY, 60 MIN ☐ OTHER ___
ESCORT:	PARTIAL ☐ TOTAL ☐	___ x WEEKLY, 60 MIN ☐ OTHER ___
TRANSPORTATION:	PARTIAL ☐ TOTAL ☐	___ x WEEKLY, 60 MIN ☐ OTHER ___

ASSISTANCE/TIME NEEDED GENERAL/HOUSEHOLD (TOTAL SECTION C): _____

D. Other Needs

Shopping Assistance*:	Errands	__ x Weekly, 60 Min ☐ Other ____
	Escort	__ x Weekly, 60 Min ☐ Other ____
Assistance with Communication:		__ x Weekly, 60 Min ☐ Other ____

ASSISTANCE/TIME NEEDED FOR OTHER NEEDS (TOTAL SECTION D): _____

TOTAL ASSISTANCE/TIME NEEDED IN ALL AREAS: _____

NOTES:

SAMPLE

_____ _____

SIGNATURE OF PERSON COMPLETING/TITLE DATE

MR/RD Form 34 (Revised 3/11)
AND
Community Supports Waiver Form PC-34 (Revised 3/11)

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR PERSONAL CARE SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

You are hereby authorized to provide ☐ Personal Care 1 (S5130) ☐ Personal Care 2 (T1019) *for:*

Participant's Name: _____ Date of Birth: _____

Address: _____
_____
_____

Phone Number: _____ Medicaid #: _____ Social Security #: _____

Only the number of units rendered maybe billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # _____

Start Date: _____

Authorized Total – PC 1 ___ Units per week (no more than 24 for adults age 21 and over; 1 unit = 15 minutes)

Authorized Total – PC 2 ___ Units per week (no more than 112 for adults age 21 and over; 1 unit = 15 minutes)

Service Tasks Requested:

☐ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
☐ Assistance with meals such as feeding, shopping for food, preparing/cooking meals, post-meal cleanup, etc.
☐ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
☐ Monitoring conditions, medications, home safety, and/or communication.
☐ Assistance with exercise, ambulation, positioning, etc.
☐ Escort services, errands, transportation

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____

Phone #: _____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-3 (Revised 3/2011)

SAMPLE

APPENDIX A-

MEDICAID
SCOPE OF SERVICES
FOR
PERSONAL CARE II (PC II), HASCI ATTENDANT CARE and
HASCI RESPITE SERVICES

A. Objectives

The objectives of the PC II/HASCI Attendant and HASCI Respite services are to restore, maintain, and promote the health status of Medicaid Home and Community-Based waiver participants through home support, medical monitoring, escort/transportation services, and assistance with activities of daily living.

B. Conditions of Participation

1. Agencies desiring to be a provider of PC II/HASCI Attendant and HASCI Respite services must have demonstrated experience in in-home personal care services or a similar service. For providers contracting after July 1, 2011 the owner and administrator of the agency must have at least three (3) years of administrative experience in the health care field.

2. Pursuant to enactment and implementation of House Bill 3012 all providers of personal care services will require a license to provide personal care services.

3. Provider agency must be housed in an office that is in a commercial zone. Office can not be located in a residence/home office. Current providers with residential/home offices must relocate to a commercially zoned office space by July 1, 2012 in order to maintain their contract.

4. Agencies must utilize the automated systems mandated by South Carolina Department of Health and Human Services (SCDHHS) Community Long Term Care (CLTC) Division to document and bill for the provision of services.

5. Providers must accept or decline referrals from SCDHHS or South Carolina Department of Disabilities and Special Needs (SCDDSN) within two (2) working days. Failure to respond will result in the loss of the referral.

6. The provider must verify the participant's Medicaid eligibility upon acceptance of a referral and monthly thereafter to ensure continued eligibility. Providers should refer to the CLTC Services Provider Manual for instructions on how to verify Medicaid eligibility.

RESPONDENT'S EXHIBIT 7

7. Providers may use paperless filing systems. When using electronic filing systems any documentation requiring signatures must be signed prior to scanning. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

8. The provider must agree to use any Competency Test provided by CLTC.

C. Description of Services to be Provided

1. The unit of service is one (1) hour of direct PC II/HASCI Attendant care service/HASCI Respite provided to/for a participant in the participant's place of residence. PC II/HASCI Attendant and/or HASCI Respite may be provided in other locations when the participant's record documents the need and when prior approved by the Case manager /Service Coordinator (CM/SC). Services are not allowed when the participant is in an institutional setting and/or ADHC setting. The amount of time authorized does not include provider transportation time to and from the participant. Services provided without a current, valid authorization are not reimbursable.

2. The number of units and services provided to each participant are dependent upon the individual participant's needs as set forth in the participant's Service Plan/Authorization. If it is determined that a participant requires more than one aide for lifting, transfers, etc., this must be prior approved by SCDHHS/SCDDSN.

3. When services are authorized for more than one SCDHHS/SCDDSN participant in the same home, the provider must document and deliver the total amount of hours authorized for each participant. For example if both participants are authorized for two (2) hours of PCII per day; the aide must provide a total of four (4) hours per day in the home.

4. Under no circumstances will any type of skilled medical service be performed by an aide except as allowed by the Nurse Practice Act and prior approved by a licensed physician. HASCI Attendants and/or HASCI Respite caregivers may provide skilled services as authorized by the county DSN Board Service Coordinator. All skilled needs are determined by RN delegation.

5. Services to be provided include:

   a. Support for activities of daily living, e.g.,
   -eating
   -bathing (bed bath, bench shower, sink bath)
   -personal grooming including dressing
   -personal hygiene

-provide necessary skin care
-meal planning and preparation
-assisting participants in and out of bed
-repositioning participants as necessary
-assisting with ambulation
-toileting and maintaining continence

b. Home support, e.g.,
-cleaning
-laundry
-shopping
-home safety
-errands

c. Monitoring of the participant's condition e.g., the type of monitoring that would be done by a family member such as monitoring temperature, checking pulse rate, observation of respiratory rate, and blood pressure.

d. Monitoring medication (for example, informing the participant that it is time to take medication as prescribed by his, or her, physician and as written directions on the box or bottle indicate). The aide cannot administer the medicine; however, this does not preclude the aide from handing the medicine container to the participant.

e. Escort services when necessary. Transportation may be provided when necessary and included in the participant's Service Plan/Authorization. The provision of transportation is optional and will depend on the provider's policy in this regard.

f. Strength and balance training.

D. Staffing

1. The provider must provide all of the following staff members; supervisory nurses may be provided through subcontracting arrangements:

a. A registered nurse(s) (RN) or licensed practical nurse(s) (LPN) who meets the following requirements:

i. Currently licensed by the S.C. State Board of Nursing.

ii. Capable of evaluating the aide's competency in terms of his or her ability to carry out assigned duties and his/her ability to relate to the participant.

iii. Able to assume responsibility for in-service training for aides by individual instruction, group meetings or workshops.

iv. Must have had background and/or training on the complex treatment issues regarding the care of the head and spinal cord injured.

v. Provider will verify nurse licensure at time of employment and will ensure that the license remains active at all times during employment. Provider must maintain a copy of the current license in the employee's personnel file. Nurse licensure can be verified at the State Board of nursing website.

http://www.llr.state.sc.us/pol.asp

b. Aides who meet the following minimum qualifications:

i. Able to read, write, and communicate effectively with participant and supervisor.

ii. Able to use the Care Call IVR system.

iii. Capable of assisting with the activities of daily living.

iv. Capable of following a care plan with minimal supervision.

v. Have a valid driver's license if transporting participants. The provider must ensure the employee's license is valid while transporting any participants by verifying the official highway department driving record of the employed individual. A copy of the driving record must be maintained in the employee's personnel file.

vi. Are at least 18 years of age.

vii. Have passed competency testing or successfully completed a competency training and evaluation program performed by an RN or LPN prior to providing services to Home and Community-Based waiver participants. The competency evaluation must contain all elements of the PC II services in the Description of Services listed above. The competency training should also include training on appropriate record keeping and ethics and interpersonal relationships.

If an LPN performs the competency evaluation, the LPN must be supervised by an RN and report all competency evaluation

results to the RN supervisor. The LPN and the supervising RN, as a confirmation of the delegation of this responsibility, must sign and date the form in addition to the LPN. All signatures must be original, signature stamps are not acceptable.

Proof of the competency evaluation must be recorded and filed in the personnel record prior to the aide providing care to waiver participants. The Division of CLTC has developed a form, called "Competency Evaluation Documentation" form which must be used to document the competency evaluation. The CLTC form may be obtained from the CLTC Central Office or on our website at http://www.scdhhs.gov/insidedhhs/bureaus/BureauofLongTermCareServices/BECOMINGAcltcPROVIDER.asp

All aides including those who are Certified Nursing Assistant's (CNA) are required to complete the competency testing or training and evaluation outlined above.

viii. Have a minimum of ten (10) hours relevant in-service training per calendar year (The annual ten-hour requirement will be on a pro-rated basis during the aide's first year of employment). Documentation shall include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, and location. Topics for specific in-service training may be mandated by SCDHHS CLTC Division. In-service training may be furnished by the nurse supervisor while the aide is furnishing care to the participant. Additional training may be provided as deemed necessary by the Provider. All instructor- led and self- study training programs, not on the prior approved list must be approved for content and credit hours by SCDHHS prior to being offered. Self-study training hours may not exceed six of the ten in-service annual training hours. The Provider shall submit proposed programs not on the prior approved list to the SCDHHS CLTC Central Office at least forty-five (45) days prior to the planned implementation. All approved training topics are at the SCDHHS agency website:

http://www.scdhhs.gov/insidedhhs/bureaus/BureauofLongTermCareServices/pc_2.asp

ix. Aides must complete a training program in the following areas:

- Confidentiality, accountability and prevention of abuse and neglect.
- Fire safety/disaster preparedness related to the specific location of services.
- First aid for emergencies, monitoring medications, and basic recognition of medical problems.
- Documentation and record keeping.
- Ethics and interpersonal relationships.
- Orientation to traumatic brain injury, spinal cord injury and similar disability.
- Training in lifting and transfers.

2. Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver:

1. The spouse of a Medicaid participant;
2. A parent of a minor Medicaid participant;
3. A step parent of a minor Medicaid participant;
4. A foster parent of a minor Medicaid participant;
5. Any other legally responsible guardian of a Medicaid participant

Family members who are primary caregivers will not be reimbursed for HASCI Respite services. All other qualified family members can be reimbursed for their provision of PCI, PCII and HASCI Attendant Care services.

3. PPD Tuberculin Test

Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-75 – Standards for Licensing page 11 of 36 section b. 1-6 for PPD Tuberculin test requirements.
http://www.scdhec.gov/health/licen/hladcinfo.htm

Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, S.C. 29201 phone (803) 898-0558.

4. Individual records must be maintained that document that each staff member has met all staffing requirements.

5. A criminal background check is required for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees (office employees required to have background checks include: administrator, office manager, nurse supervisor, and persons named on organizational chart in management positions). All criminal background checks must include all data for the individual with no limit on the timeframe being searched. Criminal background checks that cover a specific time period such as seven or ten year searches are not acceptable. The criminal background check must include statewide (South Carolina) data. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

- Participant/responsible party must be notified of the aide's criminal background, i.e. felony conviction, and year of conviction.
- Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care; this statement must be placed in the participant record.

Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the provider's discretion.

Hiring of employees with misdemeanor convictions will be at the provider's discretion. Employees hired prior to July 1, 2007 and continuously employed since then will not be required to have a criminal background check.

6. Providers will be required to check the CNA registry and the Office of Inspector General (OIG) exclusions list periodically for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on either of these lists is not allowed to provide services to Waiver participants or participate in any Medicaid funded programs. The website addresses are listed below:

CNA Registry - www.pearsonvue.com
OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

E. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section.

1. The provider must obtain a Service Plan/Authorization for PCII/HASCI Attendant care and/or HASCI Respite services from the CM/SC. The authorization will designate the amount, frequency and duration of service for participants in accordance with the participant's Service Plan/Authorization. The provider must obtain an updated SCDHHS CLTC Service Plan from the case manager yearly. The provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration. The provider must adhere to those duties which are specified in the Service Plan/SCDDSN/HASCI Authorization in developing the provider task list. This provider task list must be developed by an RN or LPN. If the provider identifies PC II/HASCI Attendant and/or HASCI Respite service duties that would be beneficial to the participant's care but are not specified in the Service Plan/SCDDSN/HASCI Authorization, the provider must contact the CM/SC to discuss the possibility of having these duties included in the Service Plan/SCDDSN/HASCI Authorization. The CM/SC will make the decision as to whether the Service Plan/Authorization should be amended to include the additional service duty. This documentation will be maintained in the participant files. For CLTC participants, no skilled services may be performed by an aide except as allowed by the Nurse Practice Act and prior approved by a licensed physician. For HASCI participants, skilled services may be performed if authorized by the Service Coordinator and overseen by RN or LPN delegation.

2. As part of the conduct of service, PC II/HASCI Attendant and/or HASCI Respite services must be provided under the supervision of an RN or LPN who meets the requirements as stated in this Scope and who will:

   a. visit the participant's home prior to the start of PC II/HASCI Attendant and/or HASCI Respite services. This visit by the provider's nurse must be recorded in Care Call from the participant's home at the time of the visit and documented in the record. If the participant has already been receiving another similar service (i.e. personal care I) a new initial visit is required prior to the start date of personal care II service. The purpose of this visit is to:

      i. review the Service Plan/Authorization and develop a task list for the aide (this task list must be developed prior to the provision of PC II/HASCI Attendant and/or HASCI Respite services),

      ii. give the participant written information regarding advanced directives,

iii. inform participants of their right to complain about the quality of PC II/HASCI Attendant and/or HASCI Respite services provided.

The supervisor will give participants information about how to register a complaint. Complaints against aides must be investigated by the provider and appropriate action taken. Documentation must be maintained in the participant and aide's file.

a. Nurse supervisors and/or aides may not discuss services authorized by SCDHHS or SCDDSN with the participant. If participants of any waiver ask about either the level of service they are receiving or the different services offered in one of the waivers the nurse supervisor and/or aide must refer that participant back to their case manager/service coordinator for additional information.

b. Be accessible by phone and/or beeper during any hours services are being provided under this contract. If the nurse supervisor position becomes vacant, SCDHHS must be notified no later than the next business day.

d. Provide and document supervision of, training for, and evaluation of aides.

e. Make a supervisory visit to the participant's place of residence within thirty (30) days after the PC II/HASCI Attendant service is initiated.

f. After the thirty (30) day supervisory visit, make a supervisory visit to the participant's place of residence at least once every four months for each participant. Four (4) month supervisory visits must be conducted by the end of the fourth month. The aide must be present during at least one of the supervisory visits during each 12 month period. For the HASCI Attendant care service, all supervisory visits scheduled will be arranged in consultation with the DSN Board Service Coordinator and documented in the participant record. For SCDHHS/SCDDSN participants, supervisory visits, including the initial visit, must be documented in the participant record and recorded in Care Call, for CLTC only, from the participant's home at the time of the visit. In the event the participant is inaccessible during the time the supervisory visit would have normally been made, the visit must be completed within five (5) working days of the resumption of PC II/HASCI Attendant services. The supervisor's report of the on-site visits must include, at a minimum:

i. Documentation that services are being delivered consistent with the Service Plan/Authorization;

ii. Documentation that the participant's needs are being met;

iii. Reference to any complaints which the participant or family member/responsible party has lodged;

iv. A brief statement regarding any changes in the participant's service needs; and,

v. Supervisor's original signature and date. Signature stamps are not acceptable.

g. Assist aides as necessary as they provide individual personal care services as outlined by the Service Plan/Authorization. Any supervision given must be documented in the individual participant's record.

3. Documentation of all supervisory visits must be filed in the participant's record within thirty (30) days of the date of visit.

Supervisory visits should be conducted as necessary if there are indications of substandard performance by the aide.

If there is a break in service which lasts more than sixty (60) days, the supervisor must complete a new initial visit when services are resumed. If the participant's condition changes enough to warrant a new service plan, the supervisor must update the task sheet to reflect the new duties.

4. The provider must maintain an individual participant record which documents the following:

a. The provider will initiate PC II/HASCI Attendant and/or HASCI Respite services on the date negotiated with the CM/SC and indicated on the Medicaid authorization. Services must not be provided prior to the authorized start date and must be provided according to the schedule as indicated on the Service Plan/Authorization.

b. The provider will notify the CM/SC within two (2) working days of the following:

i. Participant's condition has changed and the Service Plan/Authorization no longer meets participant's needs or the participant no longer appears to need PC II/HASCI Attendant and/or HASCI Respite services.

ii. Participant is institutionalized, dies or moves out of the service area.

iii. Participant no longer wishes to receive PC II/HASCI Attendant and/or HASCI Respite services.

iv. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

c. The provider will maintain a record keeping system which documents:

i. **For SCDHHS (CLTC) participants:** The delivery of services in accordance with the SCDHHS CLTC Service Plan. The provider shall not ask the participant/responsible party to sign any log or task sheet. The task sheet must be reviewed, signed, with original signature (signature stamps are not acceptable), and dated every two weeks by the supervisor. Task sheets must be filed in the participant's record within 30 days of service delivery.

ii. Task sheets/Daily logs can include multiple services on the same sheet as long as the services can be easily identified and tasks performed can be distinguished. For example if a participant receives PCII and PCI services, both can be documented on the same sheet as long as each service can be easily identified.

iii. **For SCDDSN participants:** The delivery of services and units provided must be in accordance with the Authorization. The provider will maintain daily logs reflecting the PCII/HASCI Attendant and/or HASCI Respite services provided by the aides for the participants and the actual amount of time expended for the service. The daily logs must be initialed daily by the participant or family member and the aide, and must be signed weekly by the participant or family member and signed with original signature (signature stamps are not acceptable), and dated by the supervisor at least once every two weeks. Daily logs must be filed in the participant's record within 30 days of service delivery. Daily logs must be made available to SCDHHS/SCDDSN upon request.

iv. All active participant records must contain at least two (2) years of documentation to include task sheets, service plans, supervisory visit documentation, any complaints, etc. Per Medicaid policy all records must be retained for at least five (5) years. Active records must contain **all** authorizations.

d. **For SCDHHS (CLTC) participants only:** For all instances in which a participant did not receive an authorized daily service, providers must indicate on the Care Call web site the reason why the service was not delivered. The provider must do this both when the provider was unable to complete the visit and when the participant was not available to receive the visit. For each week in which there are missed visits, the provider must indicate the reason on the web site by the close of business the following week. A missed visit report is not required for SCDDSN/HASCI participants.

e. Whenever two consecutive attempted or missed visits occur, the local SCDHHS/SCDDSN office must be notified. An attempted visit is when the aide arrives at the home and is unable to provide the assigned tasks because the participant is not at home or refuses services. A missed visit is when the provider is unable to provide the authorized service. These instances must be documented in the participant record as well as in Care Call.

5. Providers must adhere to all Care Call policies and procedures as indicated in the Care Call Users Manual. The Care Call Users Manual can be obtained from the Care Call website: https://scc.govconnect.com

F. **Children's Personal Care Requirements**

The requirements listed in this section are in addition to the requirements as listed in this scope for PCII services. Children's PC services are reimbursable when the following conditions are met:

1. Child is under 21
2. Provided in the participant's place of residence
3. Authorized by SCDHHS/SCDDSN

The CM/SC will determine the need for personal care services and develop a service plan that outlines the child's needs. This service plan will only be updated as needed.

G. Compliance Review Process

The SCDHHS Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

The following chart outlines how reviews are scored:

Sanction Level

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1=less serious, 2 = serious, 3 = very serious

Client Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC II services initiated?	Y,N,NA	3
Was the initial supervisory visit documented in Care Call?	Y,N,NA	3
Does provider maintain individual client records?	Y,N	2
Did provider give participant written information regarding advanced directives?	Y,N,NA	1

There are five types of sanctions:

- Correction Plan – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a corrective action plan outlining how and when deficiencies will be corrected (or have been corrected) and outline a plan of how they will avoid future deficiencies.

- 30-day suspension – At this level, new referrals are suspended for 30 days. The provider will also be required to submit a corrective action plan. If the corrective action plan is approved, the suspension is automatically lifted at the end of the 30-day period; indicates moderate deficiencies.

- 60-day suspension – At this level, new referrals are suspended for 60 days. The provider will also be required to submit a corrective action plan. If the corrective action plan is approved, the suspension is automatically lifted at the end of the 60-day period; indicates substantial deficiencies.

- 90-day suspension – Indicates serious and widespread deficiencies; the 90-day suspension of new referrals will only be lifted after an accepted

corrective action plan is received. In addition, an acceptable follow-up review visit will be conducted if warranted.

- Termination – Indicates very serious and widespread deficiencies, generally coupled with a history of bad reviews. Termination is a last resort.

We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

Calculating process

- The level of sanction will be decided based on the total score of the provider's current review and the provider's review history, which is converted from the deficiency percentage.
- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.
- Since each level has different severity, multiple points will be added on each class's score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

Example:			
Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score scale & Sanction Level

Sanction Type	Final score	With Good History*
Correction Plans	0-99	0-149
30 Days Suspension	100-199	150-249
60 Days Suspension	200-299	250-349
90 Days Suspension	300-399	350-449
Termination	>400	>450

Good History is determined based on previous review scores. For example, If a provider's previous review had a total score of 50 and their current review has a

score of 120, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If the reviewer arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination.

H. Administrative Requirements

1. The provider must inform SCDHHS of the provider's organizational structure including the Provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training and employee evaluations. The provider agency shall notify SCDHHS within three (3) working days in the event of a change in the agency administrator, address, phone number or an extended absence of the agency administrator.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document should include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The provider agency shall acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list SCDHHS – CLTC as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will develop and maintain a Policy and Procedure Manual that describes how activities will be performed in accordance with the terms of the

requirements of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body and personnel and will be made available to SCDHHS upon request.

6. The provider must comply with Article IX, Section Z of the Contract regarding safety precautions. The provider must also have an on-going infectious disease program to prevent the spread of infectious diseases among its employees.

7. The provider shall ensure that key agency staff are accessible in person, by phone, or by beeper during compliance review audits conducted by SCDHHS and/or its agents.

8. The provider will ensure that its office is open and staffed by qualified personnel during the hours of 10:00 am to 4:00 pm, Monday through Friday. Outside of these hours, the Provider agency must be available by telephone during normal business hours, 8:30 am to 5:00 pm, Monday through Friday. Failure to maintain an open and staffed office as indicated will result in sanctions as outlined in section G, last paragraph. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

9. The provider must have an effective written back-up service provision plan in place to ensure that the participant receives the PC II/HASCI Attendant services as authorized. Whenever the provider determines that services cannot be provided as authorized, the CM/SC must be notified by telephone immediately.

10. The provider shall provide SCDHHS a list of regularly scheduled holidays the coming calendar year each September. The provider shall not be required to furnish services on those days. The PC II/HASCI Attendant and/or HASCI Respite provider agency must not be closed for more than two (2) consecutive days at a time, except when a holiday falls in conjunction with a weekend. If a holiday falls in conjunction with a weekend, a PC II/HASCI Attendant and/or HASCI Respite provider agency may be closed for not more than four (4) consecutive days.

Revised: July 1, 2011

Respite Care

Definition: Services provided to participants unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of Respite Care furnished in a facility approved by the State that is not a private residence. Respite Care will be provided in the following location(s):

- Participant's home or place of residence, or other residence selected by the participant/representative
- Foster Home
- Medicaid-certified ICF/MR
- Group home (i.e. CTH I or II)
- Licensed Respite Care facility
- Licensed Community Residential Care Facility
- Licensed Nursing Facility

Respite may be used on a regular basis to provide relief to caregivers or in response to a family emergency or crisis.

In-home Respite can be provided up to twenty-four (24) hours in a calendar day in a variety of settings. The unit of service is one hour.

Institutional Respite is provided on a daily basis in a nursing facility (NF) or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Institutional Respite may be provided in a SCDDSN Regional Center or in a community-based ICF/MR that has been approved by the State and that is not a private residence. The unit of service is one day when the participant is present in the facility at midnight.

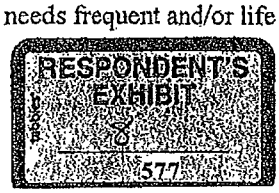
Service Limits: In-home Respite Care (provided outside of a Medicaid-certified ICF/MR or NF) is limited to a maximum of 68 units per calendar month, as determined by SCDDSN assessment. Unused units from one month cannot be banked (i.e. held in reserve) for use during a later month. An exception of up to 240 units per month may be authorized due to the following special need circumstances: 1) the caregiver's hospitalization or need for medical treatment; 2) the participant's need for constant hands-on/direct care and supervision due to a medically complex condition or severity/degree of disability; or 3) seasonal relief for those over age 12 who attend school and whose parents work, where care is needed during summer (June, July and August) break from school. These exceptions must be approved by DDSN. To request an exception, the Service Coordinator must complete the Request for Respite Limit Exception (MR/RD Form REXCP) and submit it to the District Service Coordination Program Coordinator. A panel assigned by the District Director will review the merits of the request and render a decision.

Note: Medically complex means that the person has a serious medical condition resulting in substantial physical impairment or disability requiring comprehensive care management defined as extensive hand-on assistance or total care on a routine basis.

The person needs extraordinary supervision and observation

OR

The person needs frequent and/or life saving administration of specialized treatments.



Note: Severe disability means that the person has substantial physical or behavioral impairment or disability such that the degree of impairment or disability requires extensive hands on assistance or total care on a routine basis.

Note: Persons receiving Residential Habilitation may not receive Respite Care through the MR/RD Waiver.

Note: A Respite caregiver and Personal Care Aide cannot render services at the same time.

Providers: *Hourly Respite* is provided by agencies contracted with DDSN as Respite providers. Respite workers must meet minimum caregiver qualifications (see the Home Supports Caregiver Certification at the end of the chapter).

Respite Care cannot be provided by a person who is legally responsible for the participant. Please refer to Department Directive 735-02-DD. However, family members may be paid to provide Respite. Family members/relatives wishing to receive payment for Respite Care rendered must complete the Statement of Legal Responsibility for Respite Services (MR/RD Form 31), acknowledging that they are not a primary caregiver of the participant and that they are not legally responsible for the participant, prior to the authorization of services. The Statement of Legal Responsibility for Respite Services (MR/RD Form 31) should be maintained in the participant's file.

Arranging for and Authorizing Services: Once it is determined that Respite Care is needed (including when a participant is placed in an ICF/MR, nursing facility or hospital due to an emergency/crisis), the need for the service and the amount and frequency of the service must be documented in the participant's Support Plan. Once the frequency has been determined, the budget information can be entered in the Waiver Tracking System (S46-Hourly; S13 Institutional; S12 Institutional – Nursing Home). Respite Care is approved at the local level. The participant must be given a choice of providers, and the offering of choice must be documented. In the case of an emergency or crisis situation, choice may not be an option. The Service Coordinator should clearly document this in the participant's file. Once the service is approved, the Service Coordinator should authorize Respite Care using the Authorization for Hourly Respite Care (MR/RD Form A-25) or the Authorization for Institutional Respite Care (MR Form A-32), as appropriate.

Completion of the MR/RD Waiver Respite Assessment (MR/RD Form 35) is not a prerequisite for authorizing the service; however, it is encouraged for participants for whom Respite is identified as an ongoing service that will be needed on a regular basis and when reducing the number of authorized units of Hourly Respite below the service limit.

The MR/RD Waiver Respite Assessment (MR/RD Form 35) is designed to supplement the Service Coordination Annual Assessment in providing detailed information regarding the participant's difficulty of care and to determine the caregiver's stress level and identify other information related to the need for Respite. The information gathered from the assessment will help the Service Coordinator/Early Interventionist determine how many units of Respite are appropriate to meet the needs of the participant and his/her caregiver.

The Service Coordinator may already have the information necessary to complete the assessment, but, in most circumstances, will have to follow-up with the participant/family for some of the information. Section II of the assessment is to be completed by the caregiver. The Service Coordinator should not attempt to complete this section with the caregiver. The following scale should be used when scoring Section II only: Never = 0, Sometimes = 2, Always = 4. The total scores will produce the following categories: 0 - 14 = Mild/No Stress; 15 - 22 = Moderate Stress; and 22 - 36 = Severe Stress.

Issues regarding payment of Respite caregivers for overnight care should be addressed according to individual DSN Board/Respite Provider policy and should be included in the agreement between the DSN

Board/Respite provider and the Respite caregiver. For purposes of Waiver budgeting, up to 24 hours of Respite per day can be authorized. However, in most cases when Respite covers a period of 24 hours or more, 8 hours of sleep will be assumed for each night. Therefore, 16 hours per day will be authorized. DSN Boards should ensure that their payment policies adhere to all U.S. Department of Labor and Internal Revenue Service regulations.

Note: Issues regarding "difficulty of care" rates will be addressed by the Financial Manager. If the Early Interventionist/Service Coordinator feel and his/her Supervisor agree that the Respite provider should be paid more than the current rate due to the difficulty of care needed for a particular participant, they may authorize a higher rate. This should be done in cooperation with the Financial Manager. Due to capitation, an increased rate does not mean that the Financial Manager will receive more money. If the rate paid to a Respite caregiver is increased for a particular participant, the Service Coordination Supervisor must send this notice in writing to the Cost Analysis Division at SCDDSN Central Office Finance so the rate can be adjusted on the Waiver Tracking System.

If Institutional Respite is to be provided in a SCDDSN Regional Center, the authorization form should be directed to the appropriate Claims and Collections Officer (See Attachment 1 for a list of Claims and Collections Officers). Included with the authorization should be a copy of the participant's Medicaid Card and any other private insurance information. The Admissions Packet must be submitted to the appropriate Placement Coordinator at the Regional Center (See Attachment 2 for a list of Placement Coordinators).

If Institutional Respite is to be provided in a community-based ICF/MR, the authorization form should be directed to the finance director of the board/provider that operates the ICF/MR. The Admissions Packet must be forwarded to the Residential Director of the Board/Provider.

The admissions packet must include:

- Medication Administration Schedule
- Psychological Evaluation
- Behavior Support Information (if applicable)
- Support Plan
- Nutritional Information
- Physical (completed within 30 days prior to start of Respite)
- Tuberculosis Test (2 step)
- Social History

The participant should bring, at the minimum, the following items when reporting to an ICF/MR or nursing home for Respite Care:

- Medications in their original containers
- Spending money
- Medicaid Card
- Clothing
- Toiletries
- Durable Medical Equipment and Supplies (e.g. diapers, wipes, etc.)

In cases of an emergency/crisis, some of this information may not be present initially, but should still be obtained and forwarded to the Regional Center Placement Coordinator or the Board/Provider Residential Director.

Under extreme circumstances, when the anticipated duration of Institutional Respite is not known, the service should be authorized for forty-five (45) days.

In order for SCDDSN Central Office to bill for institutional respite, the Service Coordinator must, on a monthly basis, complete the Respite Care Individual Service Report (MR Form IR/ISR). This form should be completed and forwarded to SCDDSN Central Office to the attention of SURB. This must be done no later than the 15th of the month following the provision of services.

If the participant is receiving Institutional Respite in a SCDDSN Regional Center, a staffing must be held within 30 days of beginning services. The SCDDSN Regional Center Staff will coordinate this meeting. The Service Coordinator, District Office SCDDSN Staff (if applicable), responsible party/family (if applicable), and Regional Center Staff must be present at the staffing. Discussions will be held in regards to the participant's progress and a decision will be made as to whether or not the participant will continue to receive Institutional Respite.

If the staffing team recommends that the participant be admitted to the Regional Center, the following steps must be completed:

- For participants who reside at home with family (not in a community residential setting), the Service Coordinator must initiate the process for approval of Critical Circumstance (Please refer to SCDDSN Directive 502-05-DD for procedures and forms).

If more restrictive placement/critical circumstance for placement in an ICF/MR is approved, the following steps should be completed.

- The Service Coordinator will notify the Placement Coordinator that the placement has been approved.
- Regional Center staff will complete an ICF/MR Level of Care if the participant has **ever** been admitted to an ICF/MR. If the participant is a new admission, the ICF/MR Level of Care will be completed by the Consumer Assessment Team. The Regional Center Staff will be responsible for submitting this packet to the Consumer Assessment Team
- Upon notification that the participant has met ICF/MR Level of Care, the Claims and Collections Officer will notify the Service Coordinator and the appropriate District MR/RD Waiver Coordinator that the participant is ready to be admitted to the Regional Center.
- The Service Coordinator will complete the Notice of Disenrollment (MR/RD Form 17) within two (2) working days and will forward a Notice of Termination of Service (MR/RD Form 16-B) to the Claims and Collections Officer to terminate Institutional Respite Care. The Service Coordinator will also remove Institutional Respite as a service being received from the services menu on the STS so that ISR reports are no longer generated.
- The Service Coordinator will terminate all other waiver services.
- The Claims and Collections Officer/Person Completing DHHS Form 181 will check the Waiver Tracking System to ensure that the participant has been disenrolled from the MR/RD Waiver before proceeding with admission of the participant to the ICF/MR and completing DHHS Form 181. A copy of DHHS Form 181 form will be forwarded to the Waiver Enrollments Coordinator. If the Claims and Collections Officer notes that the participant continues to remain enrolled in the MR/RD Waiver, he/she will notify the appropriate District MR/RD Waiver Coordinator.

If the staffing team recommends that the participant continue to receive Institutional Respite at the SCDDSN Regional Center, the following steps must be taken:

- Another staffing must be held within 30 days of the initial staffing. The SCDDSN Regional Center Staff will coordinate this second meeting. The Service Coordinator, District Office SCDDSN Staff (if applicable), responsible party/family (if applicable), and Regional Center Staff **must** be present at the staffing. Discussions will be held again regarding the participant's progress, and a decision will be made as to whether or not the participant will continue to receive Institutional Respite or if the team recommends admission to an ICF/MR.

  - If it is decided that the participant will continue to receive Institutional Respite, the Service Coordinator will notify the MR/RD Waiver Program Coordinator and the Director of Service Coordination and Plan Development at SCDDSN Central Office of this decision. This may be done via e-mail. The Service Coordinator must also complete a new Authorization for Institutional Respite Care (MR Form A-32) and forwarded it to the Claims and Collections Officer and SCDDSN Central Office (Attention: SURB Respite Care Authorizations).

  - If the team recommends that the participant be admitted to an ICF/MR, the procedures outlined above must be followed.

Depending on the circumstances surrounding the need for Institutional Respite, multiple staffings may result in a decision that Institutional Respite Care continue for an extended period of time. The above steps must be followed and a staffing must be held at least every 30 days. SCDDSN Central Office must be notified as outlined above.

If a participant is admitted during a crisis on the weekend or in the evening, service may be authorized verbally and the Authorization for Services (MR/RD Form A-32) completed on the next business day. The form should be completed by the person that gave verbal approval for Institutional Respite. In this case he/she may authorize that the service began on the date that verbal approval was given and may date his/her signature on the authorization as the start date. This authorization should come from the Service Coordinator, the Service Coordination Supervisor or the Executive Director. All of this should be carefully documented in the participant's file to include the verbal authorization.

Note: While a participant is receiving Institutional Respite, he/she may continue to receive Assistive Technology (medical supplies) or Prescribed Drugs through the MR/RD Waiver. All other waiver services must be terminated.

Monitoring Services: The Service Coordinator must monitor the service for effectiveness, usefulness and participant satisfaction. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following guidelines should be followed when monitoring Respite Services:

- This service may be monitored during a contact with the participant/family or service provider. It may also be monitored during a review of notes completed during a Respite stay.
- Monitoring of the participant's health status should always be completed as a component of Respite Care monitoring.
- Monitoring should start over as if it is the start of service any time there is a change of provider.

Hourly Respite

- Services should be monitored at least once during the first month of service.
- Services should be monitored at least once during the second month of service.
- Services should be monitored at least quarterly (i.e. within 3 months of the previous monitoring) thereafter.

Institutional Respite

- Services should be monitored at least bi-weekly during the first four weeks of service.
- Services should be monitored at least monthly (i.e. within one month of the previous monitoring) thereafter.

Some questions to consider during monitoring include:

- Is the participant receiving Respite Care as authorized?
- Does the provider show up on time and stay the scheduled amount of time?
- Does the provider show the participant courtesy and respect?
- Is the participant satisfied with the current respite provider?
- Does the caregiver feel that he/she is receiving enough relief from providing for the participant's care?
- Does the service need to continue at the current amount/frequency?
- Is there need for additional Respite to be requested at this time?
- Is the participant pleased with the care being provided, or is assistance needed in obtaining a new caregiver?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

Attachment 1

South Carolina Department of Disabilities and Special Needs
Regional Center Claims and Collections Officers

Midlands Center
8301 Farrow Road
Columbia, SC 29203-3294
(803) 935-7364
Fax: (803) 935-6177

Whitten Center
P.O. Box 239
Clinton, SC 29325
(864) 938-3165
Fax: (864) 938-3115

Coastal Center
9995 Jamison Road
Summerville, SC 29485
(843) 821-5810
Fax: (843) 821-5889

Pee Dee and Saleeby Center
714 National Cemetery Road
Florence, SC 29502-3209
(843) 664-2613
Fax: (843) 664-2692

Attachment 2

South Carolina Department of Disabilities and Special Needs
Regional Center Placement Coordinators

Midlands Center
8301 Farrow Road
Columbia, SC 29203-3294
(803) 935-6037
Fax: (803) 935-7678

Whitten Center
P.O. Box 239
Clinton, SC 29325
(864) 938-3396
Fax: (864) 938-3115

Coastal Center
9995 Jamison Road
Summerville, SC 29485
(843) 821-5854
Fax: (843) 821-5800

Pee Dee and Saleeby Center
P.O. Box 3029
Florence, SC 29501
(843) 664-2635
Fax: (843) 664-2692

South Carolina Department of Disabilities and Special Needs
Statement of Legal Responsibility for Respite Services

Participant's Name: _____

SSN: _____

Date of Birth: _____

Respite Care is defined as care provided to the SCDDSN participant in the absence of the caregiver or when the caregiver needs relief from the responsibilities of care giving. A participant's primary caregiver(s) cannot provide Respite. The primary caregiver(s) of the participant noted above is/are:

_____

_____

South Carolina Medicaid Policy prohibits anyone who is legally responsible for the health care decisions of another to be paid for rendering Respite Care to that person. If you are legally responsible for the health care decisions of the participant noted above, you cannot be paid for providing Respite Care.

By signing this statement you acknowledge that:

- you are <u>not</u> a primary caregiver of the participant noted above; AND
- you are <u>not</u> legally responsible for his/her health care decisions.

I am not a primary caregiver of the person noted above; and I am not legally responsible for the person noted above.

_____ _____

Signature Date

_____

Printed Name

SAMPLE

South Carolina Department of Disabilities and Special Needs
Mental Retardation/Related Disabilities Waiver
Respite Assessment

Participant Name: _____

Social Security Number: _____

Age: _____

DSN Board/Provider: _____

Service Coordinator/Early Interventionist Name: _____

Participant's Primary Caregiver(s):

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Participant's Primary Diagnosis (check only one):

☐ MR ☐ RD-Autism ☐ RD-Other _____ ☐ Other _____

Additional Diagnosed Conditions (check all that apply):

☐ Blindness
☐ Cerebral Palsy
☐ Brain or neurological damage
☐ Chronic brain syndrome
☐ Chemical dependence
☐ Deafness
☐ Epilepsy or seizures
☐ Mental illness (e.g. Psychosis, Schizophrenia, etc.)
☐ Situational mental health problems
☐ Other _____

Is this participant on the SCDDSN Critical Circumstance list? ☐ Yes ☐ No

Part I. Supervision Needs

☐ Requires occasional/little support during the day (outside of visual supervision for 1-3 hour periods)

☐ Requires limited support and supervision (within the same room or nearby, outside of visual supervision for 1 hour periods)

☐ Requires extensive, moderately intense support and supervision (within the same room or nearby, outside of visual supervision for 15 minute periods)

☐ Requires pervasive, continuous, highly intense support and supervision (direct, continuous visual contact)

Comments: _____

TRUE COPY

Part II: Caregiver Stress:

Service Coordinator/Early Interventionist: Please provide this section of the assessment to the caregiver(s) for them to complete and return to you. This may be completed over the phone, during a home visit, or by mailing it to the caregiver. This section is designed to determine the amount of stress the parent/caregiver/guardian(s) is/are experiencing.

Caregiver(s): The information requested below may seem personal; but, we must understand the stress that you may be experiencing in order to provide you with relief. The following is a list of statements which reflect how people may feel when taking care of another person. After each statement, indicate how often you feel this way (i.e. never, sometimes or always) by placing a check mark in the corresponding box. There are no right or wrong answers.

QUESTION	Never	Sometimes	Always
1. How often do you feel that you don't have enough time for yourself?			
2. How often do you feel stressed and overwhelmed between caring for yourself and your family and trying to meet other responsibilities?			
3. Are you afraid of what the future holds for your relative if something were to happen to you or your family?			
4. Do you feel you do not or will not have enough money to care for your participant?			
5. Do you feel your health has suffered because of the care you provide to your family?			
6. Do you feel you don't have as much privacy as you would like because of your relative?			
7. Do you feel you will be unable to take care of your relative much longer?			
8. Do your responsibilities for yourself and your family make you feel out of control?			
9. Do you feel that you do not have enough time for each member of your family?			

Part II Score: _____ (See Respite Service Chapter for Instructions)

Part III: Request for Respite and General Information

1. Does/do the primary caregiver(s) have any health/medical/mental health issues? If yes, explain. ☐ Yes ☐ No

   _____

2. If respite is needed to enable the primary caregiver(s) to work/attend school, indicate what other resources have been explored to meet this need and the primary caregiver's work/school schedule.

   _____

3. Is the primary caregiver responsible for providing care for other individuals (e.g. elderly parent(s), other children, another disabled participant, etc.)? If yes, for whom? ☐ Yes ☐ No

   _____

4. What is the household composition?

   Number of Adults: _ Age(s):

   Number of Children: __ Age(s): _____

5. Are there friends, neighbors, church members and/or extended family members who assist in caring for the participant? If yes, who? ☐ Yes ☐ No

   _____

6. Are there opportunities for [caregiver] spouses to spend time together without having to provide direct care for this participant? If yes, how often and who assists? ☐ Yes ☐ No ☐ N/A

   _____

7. Are there any needs that the participant has on his/her Support Plan that are not being met? If so, please list.
   ☐ Yes ☐ No

   _____

8. What services is the participant currently receiving (through any funding source)?

   ☐ OT/PT/Speech
   ☐ Attends Public School
   ☐ Adult Day Health Care
   ☐ Prevocational/Day Services
   ☐ Participant is homebound
   ☐ EI Services
   ☐ Personal Care (amount/frequency): _____
   ☐ Nursing (amount/frequency): _____
   ☐ Family Support funds for _____
   ☐ Assistive Technology
   ☐ Companion Services
   ☐ Behavior Support/Psychological Services
   ☐ Day Care
   ☐ Applied Behavior Analysis (ABA Therapy)
   ☐ Summer Camp

9. If skilled tasks are required during respite for this participant (e.g. medication administration, tube feedings, suctioning, etc.), what is the plan for these tasks to be completed by a qualified family member or Nurse?

   _____

SAMPLE

10. Is/are the primary caregiver(s) being paid to provide Personal Care services to the participant? ☐ Yes ☐ No

11. How much time every day/week is/are the caregiver(s) responsible for caring for the participant (excluding sleep time)?

_____

12. Does/do the caregiver(s) experience sleepless nights or is/are he/she/they unable to sleep consistently due to the care of their participant? If yes, explain. ☐ Yes ☐ No

_____

13. Have there been any changes of circumstances in the participant's home that have added additional stressors (e.g. death of parent, death of spouse, divorce, relocation, etc.)? If yes, explain. ☐ Yes ☐ No

_____

14. Has/have the caregiver(s) experienced any loss of income due to caring for the participant? ☐ Yes ☐ No

15. Has [one of] the caregiver(s) had to quit his/her job or reduce his/her hours in order to care for the participant? ☐ Yes ☐ No

Total Units of Respite Care *requested* (by the participant/caregiver) per month: _____

Total Units of Respite Care recommended (by the Service Coordinator) per month: _____

Include justification for or against requested number of weekly units: _____

_____ _____

Signature of Person Completing Assessment **Date**

SAMPLE

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR HOURLY RESPITE CARE
TO BE BILLED TO FINANCIAL MANAGER

TO: _____

You are hereby authorized to provide Hourly Respite Care *for:*

Participant's Name: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____ **Medicaid #** _____

Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service.

Start Date: _____

Authorized Total: ___ **Units per month (1unit = 1 hour)**

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____

Phone # _____

SAMPLE

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-25 (Revised 12/09)

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR INSTITUTIONAL RESPITE CARE
TO BE BILLED TO FINANCIAL MANAGER

SAMPLE

TO:
- ☐ Coastal Center
- ☐ Midlands Center
- ☐ Pee Dee Center
- ☐ Saleeby Center
- ☐ Whitten Center
- ☐ Community ICF/MR (name): _____
- ☐ Nursing Facility (name): _____
- ☐ Hospital (name): _____

You are hereby authorized to provide
- ☐ Institutional Respite
- ☐ Institutional Respite – Nursing Home *for:*

Participant's Name: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____ **Medicaid #:** _____

Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service.

Start Date: _____

Authorized Total: ____ **Units (One unit = one night spent at the ICF/MR facility)**

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____

Phone # _____

_____ _____
Signature of Person Authorizing Services Date

The participant cannot be admitted to the ICF/MR (DHHS 181 completed) without first notifying the Service Coordinator named above and verifying that the participant has been disenrolled from the MR/RD Waiver.

MR/RD Form A-32 (Revised 12/09)

South Carolina Department of Disabilities and Special Needs
Mental Retardation/Related Disabilities Waiver
Request for Respite Limit Exception

Participant's Name: _____ *SS#*: _____

Service Coordination Provider: _____

Service Coordinator: _____ *Phone*: _____

Indicate the category (Select One) that describes the reason for the exception request. Based on the category selected, provide or submit the information required for consideration of the request.

☐ **Caregiver hospitalized or receiving medical treatment**

☐ Documentation from the caregiver's physician of his/her condition and anticipated treatment and/or recovery schedule must be submitted. If commute time must be considered, please indicate the location where treatment will be provided and round-trip distance from the caregiver's home.

Also document reason that secondary caregiver (if applicable) is unable to temporarily fulfill primary caregiver's duties.

☐ The SC Annual Assessment (and/or other documents) must clearly and specifically reflect the care and supervision needs of the person for whom respite is requested. The needs of the person must justify the additional respite requested in consideration of all natural and paid support already received by person.

☐ **Need for constant hands-on/direct care and supervision due to medically complex condition OR severe disability**

☐ The SC Annual Assessment (and/or other documents) must clearly and specifically reflect the person's medically complex condition or severe disability.

Medically complex means that the person has a serious medical condition resulting in substantial physical impairment or disability requiring comprehensive care management defined as extensive hand-on assistance or total care on a routine basis.
The person needs extraordinary supervision and observation

OR

The person needs frequent and/or life saving administration of specialized treatments.

Severe disability means that the person has substantial physical or behavioral impairment or disability such that the degree of impairment or disability requires extensive hands on assistance or total care on a routine basis.

☐ The SC Annual Assessment (and/or other documents) must clearly and specifically document the care and supervision needs of the person for whom

respite is requested. The needs of the person must justify the additional respite requested in consideration of all natural and paid support already received by person.

☐ **Seasonal relief during the summer (June, July and August) for a school student over age 12 whose caregiver/guardian works and for whom Support Center services are not available**

- ☐ Assure that person attended school and is between 13 and 21 years of age.
- ☐ Verification that Support Center services are not available
- ☐ Statement of caregiver employment status, including work hours and commuting time
- ☐ The SC Annual Assessment (and/or other documents) must clearly and specifically document the care and supervision needs of the person for whom respite is requested. The needs of the person must justify the additional respite requested in consideration of all natural and paid support already received by person.

Amount of Respite Requested: _____

List all services this person receives:

_____

Provide a two week schedule that shows how/when services and supports (including natural supports) are provided. Include the anticipated schedule for Respite: For example:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
PC2: 8A-10A RSP: 10A-8P NS: 8P–8A	PC2: 7A–8A DAY SVS: 8A-3P RSP: 3P–10P NS: 10P–7A	PC2: 7A–8A DAY SVS: 8A-3P RSP: 3P–10P NS: 10P–7A	PC2: 7A–8A DAY SVS: 8A-3P RSP: 3P–10P NS: 10P–7A	PC2: 7A–8A DAY SVS: 8A-3P RSP: 3P–10P NS: 10P–7A	PC2: 7A–8A DAY SVS: 8A-3P RSP: 3P–10P NS: 10P–7A	PC2: 8A-10A RSP: 10A-8P NS: 8P–8A

SAMPLE

Sunday

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Justification ***(Describe how the requested hours would meet a documented need and the consequences of the service not being provided):***

Service Coordinator	Date
Service Coordination Supervisor	Date
Executive Director/Designee	Date

SAMPLE

DDSN Approval

District Office

Amount of Respite Approved: _____

_____ _____

District Director Date

SAMPLE

MR/RD Form REXCP (10/09)

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
Home and Community Based Waiver
Respite Care
Individual Service Report

Month & year: _____

Participant Name: _____

Participant SSN: _____ Medicaid #: _____

Region: _____ Provider Name: _____

Paid Number: _____ Provider Number: _____

Service Coordinator's Name: _____

Service Coordinator's Signature: _____

Each service reported must be documented in Participant's File

Date of Service	Beginning Time (Hours/Minutes)	Ending Time (Hours/Minutes)	DDSN Use	Date of Service	DDSN Use
	:	:			
	:	:			
	:	:			

SC Department of Disabilities & Special Needs
Home Supports
Caregiver Certification

Effective February 2008

The following guidelines apply to Individual Rehabilitation Supports, MR/RD Waiver and HASCI Waiver funded home supports that are provided by DSN Boards. These guidelines supersede portions of DDSN Administrative Agency Standard relating to Staff Development and Training (136), and all other policies, directives, or guidelines regarding the provision of designated services through a DDSN Home and Community Based Waiver or Rehabilitation Supports. All payments must be made directly to the provider of the service (caregiver) and cannot be made to the family or the recipient. Payments will not be made for services rendered by relatives of the recipient except as defined by South Carolina Medicaid Home and Community Based Waiver policy. Services covered in these guidelines are:

MR/RD Waiver:	**Respite, Companion, and Attendant**
HASCI Waiver:	**Respite, Personal Assistance/Attendant**
CS Waiver:	**Respite, In-Home Support**
PDD Waiver:	**Therapist**

Minimum qualifications for caregivers:

- ☐ The caregiver will have the ability to read, write and speak English.
- ☐ The caregiver will be at least 18 years of age.
- ☐ The caregiver will be capable of aiding in the activities of daily living (not required for Rehabilitation Supports caregiver if not part of the job for which he/she is hired).
- ☐ The caregiver will be capable of following a plan of service with minimal supervision.
- ☐ The caregiver will have no record of abuse, neglect, crimes committed against other people or felonious convictions of any kind.
- ☐ The caregiver will be free from communicable and contagious diseases.
- ☐ The caregiver must maintain a valid Driver's License and be insurable (if driving is required as part of the job).
- ☐ The caregiver will document hours worked and the nature of the tasks performed. The waiver recipient or his/her designee (i.e., parent, sibling, etc.) will verify the documentation.
- ☐ If providing Personal Assistance/Attendant Care, supervision will be provided by a RN or as otherwise allowed within the provision of state law.
- ☐ The caregiver will demonstrate competency in required training. (See attached training requirements for caregivers.) Training will include the attached minimum guidelines for training as well as any special techniques/procedures/equipment required to adequately provide services for the individual prior to assuming responsibility.

Training Requirements for Caregivers

All caregivers must have the skills and abilities to provide quality services for the people they serve. Minimally, caregivers must demonstrate competency in the following areas (taken directly from the pre-service curriculum) before services are provided. *Hours in parentheses are estimates of the time needed to achieve competency and may be higher or lower depending on the existing skill level of the caregiver and the skills required for serving a particular waiver recipient.*

1. Confidentiality, Accountability and Prevention of Abuse and Neglect (1.5 hours)

2. First Aid (4 hours)

3. Fire Safety/Disaster Preparedness related to the specific location of services (1 hour)

4. Understanding Disabilities (MR/RD and Autism)
   OR
   Orientation to Head and Spinal Cord Injuries (HASCI). This training must be specifically related to the person/family needing services (1-3 hours)

5. Signs and Symptoms of Illness and Seizures (1 hour)

The following describes two ways in which caregivers can demonstrate competency:

1. Taking and passing tests (curriculum) in the above categories. Tests may be taken as part of DSN Board Training or may be taken when training does not occur.

2. Recipient/responsible party can approve caregiver competency for items 3 - 5 above, but cannot sign off on items 1 or 2.

Caregivers must also demonstrate competency in any person-specific special techniques / procedures / equipment and must be oriented to the habits, preferences, and interests of the person. Caregivers must be able to communicate with the recipient. The recipient or family will typically provide this training to the caregiver. DSN providers, however, should allow access, upon request, to training classes and/or assist with caregiver training. The recipient/responsible party, prior to services beginning, must complete the attached Caregiver Certification form for each caregiver. This form along with supporting documentation (training records, tests, etc.) will be maintained by the local DSN Board.

SAMPLE

HOME SUPPORTS
CAREGIVER CERTIFICATION

Caregiver Information:

Name: _____

Social Security Number: _____

Address: _____

_____

Phone Number: _____

The above named caregiver has demonstrated competency in the areas noted below through the successful completion of training or by exemption from the training as approved by me.

Name of Training	Training/Date	Exemption/Date
Confidentiality, Accountability & Prevention of Abuse and Neglect		XXXXXXXXXXXXXXX
First Aid		XXXXXXXXXXXXXXX
Fire Safety/Disaster Preparedness		
Understanding Disabilities (MR/RD or Autism) OR Orientation to Head and Spinal Cord Injuries		
Signs and Symptoms of Illness & Seizures		

The above named caregiver has been oriented to the habits, preferences and interests of _____ and is competent to perform the tasks needed to provide his/her care.

_____ _____

Participant/Responsible Party **Date**

_____

Relationship of Responsible Party to Participant

Form D1

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

TELEPHONE (803) 256-2017

FAX (803) 256-2213

December 9, 2011

Mr. Robert French
SC Dept. Of Health and Human Services
Division of Appeals and Hearings
PO Box 8206
Columbia, SC 29202



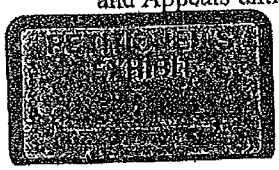
Richard G. Hepfer, Esquire
SC Dept. Of Health and Human Services
PO Box 8206
Columbia, SC 29202

Dear Gentlemen:

We received the December 7, 2011, order on our motion to amend from Judge Robinson yesterday. A copy of the order is enclosed. I think that this order lends some clarity to the effect of Judge Robinson's initial order. Judge Robinson clearly adopted the holding in *Hickey v. DHHS*, finding the reductions at issue in this case to be invalid. The December 7 order clearly confirms that the decision to reduce or terminate services has been reversed. Judge Robinson states that an evidentiary hearing must be provided "before taking any further actions with regards to Appellant's benefits under the MR/RD waiver program." We are unaware of any "further action" that DHHS intends to take because we have not received notice of further action. Given that Judge Robinson's order determined that reductions made without promulgating regulations are invalid and the order prohibits DHHS from reducing the services and supplies that were at issue in the consolidated case, I am afraid that my clients do not understand what issues might possibly be heard at the hearings that have been scheduled in January. My clients still have not been provided with notice of the regulation or law that supports whatever action may be taken by DHHS. Due Process requires that they know, in time to prepare for any hearing, what issues will be heard and the basis for what unknown actions HHS may intend to take.

The four cases were consolidated by Judge Robinson. I do not think that there is any authority to overrule her order to consolidate these cases and we object to separating the cases she consolidated.. We are requesting that DHHS provide us with all of the required information set forth in 42 C.F.R. 431.201 for any hearing that is scheduled and that any "further actions" described in Judge Robinson's order be clearly identified so that we can respond appropriately.

We are also requesting that no ex parte communications occur between anyone at the Office of Hearings and Appeals and DHHS or DDSN employees outside of the Office of Hearing and Appeals until this case is ended. I request notice and the opportunity to participate in any



CERTIFIED SPECIALIST IN ESTATE PLANNING AND PROBATE LAW

Received 12-19-11 BKS

communications or meetings between the Office of Hearings and Appeals and attorneys or employees of DHHS and DDSN.

I will be contacting my clients to determine whether they intend to appeal the issues raised on our Rule 59 motion to the South Carolina Court of Appeals. In the interim, we are requesting a status conference to clarify any issues that might be addressed if a hearing is determined to be necessary and that the hearings scheduled for January 3 through January 6 be unscheduled.

Sincerely,

Patricia L. Harrison

cc: Carolyn Myers
Chip Eubanks
Barbara Morgan
Bronson Edge
Sandra Ray, Esq.

Cornell University Law School

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TITLE 42 > CHAPTER 7 > SUBCHAPTER XIX > § 1396r

§ 1396R. REQUIREMENTS FOR NURSING FACILITIES

(a) "Nursing facility" defined

In this subchapter, the term "nursing facility" means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care,

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1395x (l) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and

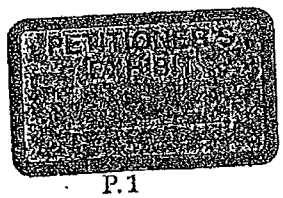
(3) meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of paragraph (1) and subsections (b), (c), and (d) of this section.

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general



2

P.1

A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which

(i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and

(ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A) of this section;

(iii) uses an instrument which is specified by the State under subsection (e)(5) of this section; and

(iv) includes the identification of medical problems.

(B) Certification

(I) In general Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(II) Penalty for falsification

(I) An individual who willfully and knowingly certifies under clause (I) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (I) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a (a) of this title.

(iii) Use of independent assessors If a State determines, under a survey under subsection (g) of this section or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency

(i) In general Such an assessment must be conducted—

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990,

and by not later than October 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident review The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use

The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) Coordination

Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort. In addition, a nursing facility shall notify the State mental health authority or State mental retardation or developmental disability authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who is mentally ill or mentally retarded.

(F) Requirements relating to preadmission screening for mentally ill and mentally retarded individuals

Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A) of this section, a nursing facility must not admit, on or after January 1, 1989, any new resident who—

(i) is mentally ill (as defined in subsection (e)(7)(G)(i) of this section) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental illness, or

(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii) of this section) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of

services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental retardation.

A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(4) Provision of services and activities

(A) In general

To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality.

(B) Qualified persons providing services

Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) Required nursing care; facility waivers

(i) General requirements With respect to nursing facility services provided on or after October 1, 1990, a nursing facility—

(I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and

(II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

(ii) Waiver by State To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if—

(I) the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel,

(II) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility,

(III) the State finds that, for any such periods in which licensed nursing services are not available, a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the facility,

(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) [1] of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to clause (iii) shall be accepted by the Secretary for purposes of this subchapter to the same extent as is the

A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g) of this section.

(d) Requirements relating to administration and other matters

(1) Administration

(A) In general

A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5) of this section).

(B) Required notices

If a change occurs in—

(i) the persons with an ownership or control interest (as defined in section 1320a-3 (a)(3) of this title) in the facility,

(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1320a-5 (b) of this title) of the facility,

(iii) the corporation, association, or other company responsible for the management of the facility, or

(iv) the individual who is the administrator or director of nursing of the facility,

the nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

(C) Nursing facility administrator

The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4) of this section.

(2) Licensing and Life Safety Code

(A) Licensing

A nursing facility must be licensed under applicable State and local law.

(B) Life Safety Code

A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(I) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(II) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

(3) Sanitary and infection control and physical environment

A nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) Miscellaneous

(A) Compliance with Federal, State, and local laws and professional standards

A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a-3 of this title) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) Other

A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) State requirements relating to nursing facility requirements

As a condition of approval of its plan under this subchapter, a State must provide for the following:

(1) Specification and review of nurse aide training and competency evaluation programs and of nurse aide competency evaluation programs

The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) of this section and that meet the requirements established under subsection (f)(2) of this section, and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii) of this section.

The failure of the Secretary to establish requirements under subsection (f)(2) of this section shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry

(A) In general

By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) of this section or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) Information in registry

The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of this section of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) Prohibition against charges

A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) State appeals process for transfers and discharges

The State, for transfers and discharges from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3) of this section, for hearing appeals on transfers and discharges of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph.

(4) Nursing facility administrator standards

By not later than July 1, 1989, the State must have implemented and enforced the nursing facility administrator standards developed under subsection (f)(4) of this section respecting the qualification of administrators of nursing facilities.

(5) Specification of resident assessment instrument

Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii) of this section. Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B) of this section, or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A) of this section.

(6) Notice of medicaid rights

Each State, as a condition of approval of its plan under this subchapter, effective April 1, 1988, must develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under this subchapter.

(7) State requirements for preadmission screening and resident review

(A) Preadmission screening

(i) In general Effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8) of this section) described in subsection (b)(3)(F) of this section for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under subsection (f)(8) of this section shall not relieve any State of its responsibility to have a preadmission screening

program under this subparagraph or to perform resident reviews under subparagraph (B).

(ii) Clarification with respect to certain readmissions The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(iii) Exception for certain hospital discharges The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual—

(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.

(B) State requirement for resident review

(i) For mentally ill residents As of April 1, 1990, in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (f)(8) of this section and based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority)—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in section 1396d (h) of this title) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

(II) whether or not the resident requires specialized services for mental illness.

(ii) For mentally retarded residents As of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (f)(8) of this section)—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under section 1396d (d) of this title; and

(II) whether or not the resident requires specialized services for mental retardation.

(iii) Review required upon change in resident's condition A review and determination under clause (i) or (ii) must be conducted promptly after a nursing facility has notified the State mental health authority or State mental retardation or developmental disability authority, as applicable, under subsection (b)(3)(E) of this section with respect to a mentally ill or mentally retarded resident, that there has been a significant change in the resident's physical or mental condition.

(iv) Prohibition of delegation A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(C) Response to preadmission screening and resident review

As of April 1, 1990, the State must meet the following requirements:

(i) Long-term residents not requiring nursing facility services, but requiring specialized services In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident,

(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

(III) clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

A State shall not be denied payment under this subchapter for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

(II) Other residents not requiring nursing facility services, but requiring specialized services In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2) of this section,

(II) prepare and orient the resident for such discharge, and

(III) provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

(III) Residents not requiring nursing facility services and not requiring specialized services In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require specialized services for mental illness or mental retardation, the State must—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2) of this section, and

(II) prepare and orient the resident for such discharge.

(IV) Annual report Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (II) and (III).

(D) Denial of payment

(I) For failure to conduct preadmission screening or review No payment may be made under section 1396b (a) of this title with respect to nursing facility services furnished to an individual for whom a determination is

required under subsection (b)(3)(F) of this section or subparagraph (B) but for whom the determination is not made.

(ii) For certain residents not requiring nursing facility level of services

No payment may be made under section 1396b (a) of this title with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.

(E) Permitting alternative disposition plans

With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require specialized services for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirements of subparagraphs (A) through (C) of this paragraph if, before April 1, 1989, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement may provide for the disposition of the residents after the date specified in subparagraph (C). The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.

(F) Appeals procedures

Each State, as a condition of approval of its plan under this subchapter, effective January 1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (A) or (B).

(G) Definitions

In this paragraph and in subsection (b)(3)(F) of this section:

(i) An individual is considered to be "mentally ill" if the individual has a serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness.

(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition (as described in section 1396d (d) of this title).

(iii) The term "specialized services" has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4) of this section.

(f) Responsibilities of Secretary relating to nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) Requirements for nurse aide training and competency evaluation programs and for nurse aide competency evaluation programs

(A) In general

For purposes of subsections (b)(5) and (e)(1)(A) of this section, the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to

(I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum,

(II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training),

(III) qualifications of instructors, and

(IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights, and procedures for determination of competency;

(III) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(IV) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.

(B) Approval of certain programs

Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on December 22, 1987;

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) of this section if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) subject to subparagraphs (C) and (D), shall prohibit approval of such a program—

(I) offered by or in a nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii) of this section that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) of this section for a period in excess of 48 hours during a week;

(b) has been subject to an extended (or partial extended) survey under section 1395i-3 (g)(2)(B)(i) of this title or subsection (g)(2)(B)(i) of this section; or

(c) has been assessed a civil money penalty described in section 1395i-3 (h)(2)(B)(ii) of this title or subsection (h)(2)(A)(ii) of this section of not less than $5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i) of this section, clauses [3] (i), (iii), or (iv) of subsection (h)(2)(A) of this section, clauses [3] (i) or (iii) of section 1395i-3 (h)(2)(B) of this title, or section 1395i-3 (h)(4) of this title, or So in original. Probably should be "clause".

(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the nursing facility.

(C) Waiver authorized

Clause (iii)(I) of subparagraph (B) shall not apply to a program offered in (but not by) a nursing facility (or skilled nursing facility for purposes of subchapter XVIII of this chapter) in a State if the State—

(i) determines that there is no other such program offered within a reasonable distance of the facility,

(II) assures, through an oversight effort, that an adequate environment exists for operating the program in the facility, and

(iii) provides notice of such determination and assurances to the State long-term care ombudsman.

(D) Waiver of disapproval of nurse-aide training programs

Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as

eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.

(3) Federal guidelines for State appeals process for transfers and discharges

For purposes of subsections (c)(2)(B)(iii) and (e)(3) of this section, by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) of this section must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from nursing facilities.

(4) Secretarial standards qualification of administrators

For purposes of subsections (d)(1)(C) and (e)(4) of this section, the Secretary shall develop, by not later than March 1, 1988, standards to be applied in assuring the qualifications of administrators of nursing facilities.

(5) Criteria for administration

The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (d)(1) of this section with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) Specification of resident assessment data set and instruments

The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3) of this section, and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) of this section for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii) of this section.

(7) List of items and services furnished in nursing facilities not chargeable to the personal funds of a resident

(A) Regulations required

Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after December 22, 1987, that define those costs which may be charged to the personal funds of residents in nursing facilities who are individuals receiving medical assistance with respect to nursing facility services under this subchapter and those costs which are to be included in the payment amount under this subchapter for nursing facility services.

(B) Rule if failure to publish regulations

If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in that subparagraph, in the case of a resident of a nursing facility who is eligible to receive benefits for nursing facility services under this subchapter, for purposes of section 1396a(a)(28)(B) of this title, the Secretary shall be deemed to have promulgated regulations under this paragraph which provide that the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this subchapter) include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Federal minimum criteria and monitoring for preadmission screening and resident review

(A) Minimum criteria

The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under subsections (b)(3)(F) and (e)(7)(B) of this section and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.

(B) Monitoring compliance

The Secretary shall review, in a sufficient number of cases to allow reasonable inferences, each State's compliance with the requirements of subsection (e)(7)(C)(ii) of this section (relating to discharge and placement for active treatment of certain residents).

(9) Criteria for monitoring State waivers

The Secretary shall develop, by not later than October 1, 1988, criteria and procedures for monitoring State performances in granting waivers pursuant to subsection (b)(4)(C)(ii) of this section.

(g) Survey and certification process

(1) State and Federal responsibility

(A) In general

Under each State plan under this subchapter, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d) of this section. The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

(B) Educational program

Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) Investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the

facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2) of this section.

(6) Special rules where State and Secretary do not agree on finding of noncompliance

(A) State finding of noncompliance and no secretarial finding of noncompliance

If the Secretary finds that a nursing facility has met all the requirements of subsections (b), (c), and (d) of this section, but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

(B) Secretarial finding of noncompliance and no State finding of noncompliance

If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d) of this section, and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary—

(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

(7) Special rules for timing of termination of participation where remedies overlap

If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d) of this section, and neither finds that the failure immediately jeopardizes the health or safety of its residents—

(A)

(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary

shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

(III) if the State, but not the Secretary, finds that the facility's participation under the State plan should be terminated, the State's decision to terminate, and timing of such termination, shall control; and

(B)

(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary shall apply.

(8) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of subchapter XVIII of this chapter.

(9) Sharing of information

Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XVIII of this chapter, including investigations by State medicaid fraud control units.

(l) Construction

Where requirements or obligations under this section are identical to those provided under section 1395i-3 of this title, the fulfillment of those requirements or obligations under section 1395i-3 of this title shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

[1] See References in Text note below.

[2] See References in Text note below.

[3] So in original. Probably should be "clause".

[4] So in original. Probably should be "paragraph".

[5] So in original. Probably should be followed by a comma.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

DEFINITION OF SPECIALIZED SERVICES

For mental illness, specialized services are those services which combined with services provided by the NF results in the continuous and aggressive implementation of an individualized plan of care that-

i) is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and as appropriate, other professionals;

ii) prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and

iii) is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

outh Carolina elects not to provide specific examples of those services at his time.

or mental retardation, specialized services are the services specified by the tate which, combined with services provided by the NF or other service roviders, results in the implementation of an individualized plan of care hat-

i) provides specialized and generic training, treatment, health services and related services that is directed toward;

ii) acquiring the behaviors necessary for the client to function with as much self-determination and independence as possible; and

iii) preventing or decelerating regression or loss of current optimal functional status.

South Carolina elects not to provide specific examples of these services at this time.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

CATEGORICAL DETERMINATIONS

Advance categorical determinations that specialized services are not needed are listed below.

a) The individual is being admitted to the nursing facility on a provisional basis for a period not to exceed 14 days to provide respite for in-home caregivers. The anticipated length of stay nullifies the effectiveness of the development and implementation of a plan of specialized services. (MR or MI).

b) The individual is being admitted to the nursing facility on a provisional basis not to exceed 7 days while alternative arrangements can be made. The admission must be at the request of the South Carolina Department of Social Services, Division of Protective Services due to a suspicion of abuse or neglect. This admission is provided on an emergency basis. The anticipated length of stay nullifies the effectiveness of a plan of specialized services. (MR or MI).

c) The individual is being admitted directly to the nursing facility from an acute inpatient setting for a period not to exceed 30 days. The admission must be necessary for treatment of the same condition that necessitated the hospitalization which may not be for treatment of a psychiatric disorder. The anticipated length of stay nullifies the effectiveness of a plan of specialized services. (MR or MI).

d) The individual has been diagnosed as having dementia concurrent with an MR diagnosis. The dementia must be substantiated by the Mini Mental State Exam. (MR only)

Advance categorical determination that nursing facility services are required is as follows.

a) The individual meets the medical eligibility criteria for Medicaid payment to a nursing facility. (MR or MI).

Susan B. Munn, MD
Family Medicine

Camden Family Care, LLC

PO Box 1437 • 1017 Fair Street • Camden, SC 29020 • (803) 424-1260 • Fax (803) 424-1230

June 24, 2011

Re: Albert (Al) Myers
DOB: 12/04/1977

To Whom It May Concern,

I am Al Myer's treating physician. I have been a practicing family physician for 7 years. I am very familiar with Al. He has been my patient since 2005. Al has athetoid quadriplegia and is prone to contractures. He has severe scoliosis, epilepsy, cerebral palsy, and is non-verbal.

Al's mother has been taking care of him, but due to her medical condition of sciatica, history of bleeding ulcers and other health problems she is not able to lift and provide around the clock care. Lifting Al could cause a rapid deterioration in his mother's physical condition and would likely lead to immediate institutionalization for him. His mother is well trained in his medical needs and is able to supervise and monitor the care provided by others in Al's home. This is the lease restrictive environment for him at the present time. She is trained to administer Al's medications and feed him via gastric tube. Living at home is the most appropriate setting for Al, as long as his mother is provided the support she needs. Al requires constant, around the clock supervision due to his extremely medically complex condition and his inability to independently exit the home in the event of a fire or other emergency. He needs nursing services for eight hours a day due to his schedule of gastric tube feeding three times a day and necessity for medication administered by gastric tube in the evenings. Al requires nursing services to monitor for and treat decubitus ulcers and also monitoring his stoma. He is at a high risk for infection and rapid decline in his health if these services are not provided.

On the days that Al attends the day program at the Kershaw DSN Board, he needs two hours of nursing services, along with two hours of PCA II services in the morning. He needs a nurse to provide tube feeding med-day for one hour. In addition, Al requires on these days two hours of nursing services to feed him at supper time and two hours of nursing services at bed time to provide his medications through a feeding tube. On the days that Al attends the day program, he needs PCA II services from 2:45 pm until 11 pm. On Saturdays, Sundays, and any day that Al isn't able to attend the Kershaw DSN program (due to sickness or the center being closed), he requires eight hours of nursing services, in addition to sixteen hours a day of PCA II services.

Al needs physical and occupational therapy in order to prevent regression and to prevent contractures. Without this therapy Al would have contractures that require surgical intervention. The amount and frequency of this service should be determined by a physical therapist and an occupational therapist. He also requires services of a speech therapist to diagnose and treat swallowing problems.

If you have any questions feel free to contact me at (803) 424-1260.

Sincerely,

Susan B. Munn, M.D.

4

Albert C. Myers [illegible]mber 30, 2011

12/4/1977

248-39-8858

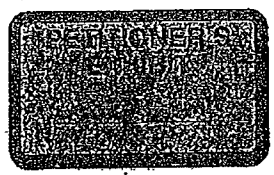
Primary Care Physician: Susan B. Munn

Dear Sir or Madam,

I am a professional in physical therapy and rehabilitation. I have a doctorate degree in physical therapy and have been Albert Myer's physical therapist. Albert is a remarkable individual who has continued to lead a happy and productive life despite his numerous health conditions. Until recently Albert has been working at the Kershaw County Department of Disabilities and Special Needs. Albert worked there for several years in a variety of task that take advantage of his numerous talents. I have been treating Albert for his two most prominent diagnosis: arthrogryposis and cerebral palsy. Physical Therapy is a key component to any patient's treatment plan with these conditions.

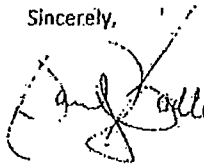
The purpose of physical therapy is to help Albert from developing further contractures. Contractures are when muscles and joints become locked into awkward and abnormal positions. This is very painful and inhibits movement. The focus of physical therapy is to stretch all of the lower extremity and trunk joints during a therapy session. Physical therapy is concentrating on preventing further painful contractures from developing and to keep current contractures from worsening. Albert currently has a windswept trunk that has to be accommodated with a molded wheelchair because of the severity of the contracture. Albert needs continued physical therapy for aggressive stretching while providing position to help prevent contractures from forming or worsening. Joint mobilization is also needed to break excessive connective tissue that may have grown around the joint since the previous treatment. A skilled physical therapist is needed for maximum benefit to Albert to attain and maintain the maximum range of motion possible at each joint.

We, his family and I, have recently seen the effects when Albert does not receive consistent physical therapy. Due to transition with his caregiver situation Albert missed a few weeks of therapy. This absence created a host of problems including difficulty with diapering/toileting and putting Albert in his wheelchair. It took several weeks of effort once Albert returned to physical therapy to increase his flexibility enough for non-painful wheelchair sitting tolerance. Albert showed a marked increase in spasticity, scissoring lower extremity pattern and decreased flexibility in hamstring and quadriceps muscles that made sitting difficult and painful without physical therapy. Albert would display signs of grimacing during stretches during this time and while be transferred to his wheelchair due to pain with range of motion during this time of inconsistent physical therapy. After three weeks of consistent physical therapy Albert was once again non-grimacing during transfers and stretches due to decreased pain during these movements.



I believe it is in Albert' st interest to continue physical therapy so th may continue to enjoy mobility with his wheelchair and decrease his pain. Albert's contractures will worsen including his windswept trunk if he is not provided with physical therapy for stretching and joint mobilization making it impossible to seat him in a wheelchair and drastically reducing his quality of life. His contractures will also begin to create problems with diapering/toileting due to his scissoring lower extremity pattern and may lead to skin breakdown because of improper cleaning because of inaccessibility to some areas. Thank you for your time and consideration into this matter.

Sincerely,



Dr. Darilyn Galloway-Coker, DPT

State of South Carolina	)	BEFORE THE APPEALS DIVISION OF THE
	)	SOUTH CAROLINA DEPARTMENT OF
County of Richland	)	HEALTH AND HUMAN SERVICES
	)	
	)	
Albert Cooper Myers,	)	
Petitioner	)	
	)	Affidavit of Treating Physician at
vs.	)	at Camden Family Care
SOUTH CAROLINA DEPT. OF HEALTH AND HUMAN SERVICES,	)	
Respondent	)	
	)	

Now comes the treating physician of Albert Cooper Myers, who swears and affirms:

1. I am a physician who is licensed to practice medicine in the State of South Carolina and I am board certified in family medicine.

2. Camden Family Practice has treated Albert Myers for than seven years.

3. Albert Myers has athetoid quadriplegia, contractures, severe scoliosis, epilepsy, cerebral and he is non-verbal.

4. Mr. Myers is unable to walk, to get out of bed or to perform any activity of daily living.

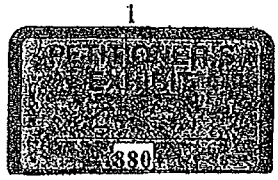
5. Because the services ordered on June 24, 2011 were not provided, it has become necessary for Mr. Myers to be institutionalized in a nursing home. Exhibit 1.

6. If the 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.

7. Respite services are not an acceptable alternative to nursing services and personal care attendant services because the low rate of pay does not attract the type of employee who has the capability to provide the supervision Mr. Myers needs.

8. The conflict which resulted from denying medical benefits (workers' compensation) and the resulting threat of legal action tremendously increased the stress on Mr. Myers' mother and has contributed to her inability to provide continuing care for him in the

6



home.

9. Due to his medical complexity and unexplained injuries received at the workshop Mr. Myers attended for many years, it became unsafe for him to continue attending that program and it his return to that program is also contraindicated by the complications of unqualified staff providing his tube feeding.

10. Mr. Myers is not able to eat regular food and he must take all nutrition through a gastric tube implanted in his stomach and he needs to continue to receive the same nutritional supplement he received at home to prevent digestive problems which may cause aspiration.

11. Mr. Myers is able to communicate through gestures and he has the mental capacity to understand where he is, making it more important that he have specialized services in addition to those service normally provided to residents of a nursing home.

12. Mr. Myers interacts with others and he needs mental stimulation to maintain his maximun functional level and to prevent depression. At the nursing home, Mr. Myers is surrounded by persons much older than he, many with cognitive impairments. Based on his age, level of socialization skills and intellectual abilities, Mr. Myers needs stimulation outside of the nursing home which should be provided by an adult companion three days a week for six hours a day.

13. In order to prevent depression and to maintain his mental health, Mr. Myers needs to continue to receive psychological services. These services are needed for one hour twice each month, or more frequently if it appears that his condition is worsening.

14. Mr. Myers needs to receive physical therapy for at least one hour a week, or as determined to be medically necessary by a qualified physical therapist.

15. Without these services, the contractures will worsen and he will lose the ability to sit upright without pain. I have reviewed the assessment of Mr. Myers' treating physical therapist and I agree with that assessment of his needs.

16. These services will 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.

17. Mr. Myers needs to receive vision services to have an eye exam annually.

18. Because of his teeth clinching, Mr. Myers must be put to sleep for dental services and he needs to receive services as determined to be necessary by his dentist. If these services are not provided in a timely manner, he risks infection which would likely require

hospitalization.

19. Mr. Myers needs to be fitted for a new mouth guard to prevent injury to his mouth that is painful and may lead to infection.

20. Poor oral status significantly increases the risk of developing respiratory infections, including pneumonia, in persons with developmental disabilities.

21. When Mr. Myers lived at home, he received one-on-one attention and assistance with turning on the television, using the phone and other activities. He needs an assessment to determine what assistive technology is needed to allow him to perform some of these activities independently.

22. In particular, Mr. Myers needs an assessment by a licensed speech and language services provider to determine his need for an adaptive communications device. Because Mr. Myers is unable to use his hands or his feet, it is likely that he will need a device that allows him to communicate with movement of his eyes.

23. A device that requires manual dexterity would be of no use to Mr. Myers.

24. Mr. Myers also needs to receive speech and language services to prevent the risk of choking. This is critically important now that he will be in a setting with less supervision than he had at home in order to prevent hospitalization.

25. Mr. Myers needs an assessment to determine whether he would be able to learn to drive a motorized wheelchair or to operate a device allowing him to change positions.

26. Mr. Myers needs a molded seat which conforms to his body in order to prevent gastrointestinal and pulmonary problems which would likely lead to hospitalization.

27. Mr. Myers needs an assessment to determine what bed is appropriate to prevent skin breakdown and to move him during the night without being awakened by a nurse physically changing his position in the bed.

28. These services and adaptive equipment are medically necessary, based on Mr. Myers' complicated medical condition.

29. Mr. Myers has been able to avoid more surgical intervention and hospitalization due to the excellent care he received at home, but the failure to provide necessary supports had resulted in that residential setting no longer being possible. Due to the deterioration of his mother's condition, he would require 24/7 supervision at home.

30. With the necessary services and supports Mr. Myers would be able to live in the

community, but the services he received were woefully inadequate.

I have read this statement and swear and affirm that it is true based on Mr. Myers' medical records and my personal knowledge of his condition. Executed on this 5 day of January, 2012.

Myers, Albert (Al) C.

33 Y old Male, DOB: 12/04/1977
106 Hunt Cup Lane, Camden, SC-29020
Home: 803-432-0931
Guarantor: Myers, Albert (Al) C. Insurance: Medicare
Benefit Integrity
Referring: Susan B. Munn, M.D.

07/07/2011 Progress Notes: Susan B. Munn, M.D.

Reason for Appointment
1. problem with G-Tube and toe black and painful

History of Present Illness
Interim history:
Pt here today with (R) great toe fungus. Nail has started turning black and the tip of the toe as well. Pt also having redness around G-tube. Pt's mother is concerned.

Current Medications
Syringes (no needles) Luer Lock 10cc Use with medications
Clonazepam 0.5 mg 1 tablet TID
Granulex Spray: apply to heel twice daily
Tegretol 100 mg/5 ml 5 cc QID

Past Medical History
Arthrogrypothics
Unilateral partial cleft lip repaired
Bilateral hip dislocation
Club feet
Cerebral palsy
Seizure disorder

Surgical History
club feet repair (bilateral) as infant
cleft lip repair as infant
Feeding tube /1990
Spinal fusion/rods placement

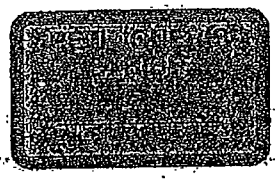
Family History
Father: deceased lung cancer
Mother: alive

Social History
no Smoking.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Pneumonia (aspiration secondary)

Review of Systems
CONSTITUTIONAL:
no loss of appetite. no weight loss.
ALLERGY:



no runny nose. no scratchy throat. no itchy eyes. no ear fullness. no sinus congestion. no stuffy nose.
RESPIRATORY:
no shortness of breath. no chest congestion.
GASTROENTEROLOGY:
no abdominal pain. no constipation. no diarrhea. no change in bowel habits.
DERMATOLOGY:
no rash, no lumps. no dry or sensitive skin.

Vital Signs
Wtw/c, HR 60/98%, RR 18, BP 90/60.

Physical Examination
GENERAL:
General appearence., pleasant, cooperative.
HEENT:
ear canals normal. tympanic membranes normal, good light reflex bilaterally. head normocephalic, atraumatic. sclera normal, anicteric. pupils ERLA. EOM intact. oral cavity normal, tongue unremarkable, no exudate noted. nose normal.
NECK:
cervical lymph nodes normal.
HEART:
PMI normal, non-displaced. rhythm regular. heart sounds normal, no murmur, rubs, or gallops noted.
RESPIRATORY/CHEST:
shape and expansion normal. breath sounds normal. rales no. wheezes no.
DERMATOLOGY:
skin warm, moist, no rashes noted, small area of ulceration on tip of toe with excar in place.

Assessments
1. CEREBRAL PALSY NEC - 343.8 (Primary)
2. Skin ulceration, amebic - 006.6

Treatment
1. Skin ulceration, amebic
Small pressure ulcer noted. Will change shoes and continue current wound care.

Follow Up
prn

Electronically signed by Susan Munn M.D. on 07/21/2011 at 12:00 PM EDT
Sign off status: Completed

Camden Family Care
1017 Fair St.
Camden, SC 29020
Tel: 803-424-1260
Fax: 803-424-1230



Myers, Albert (Al) C.

33 Y old Male, DOB: 12/04/1977
106 Hunt Cup Lane, Camden, SC-29020
Home: 803-432-0931
Guarantor: Myers, Albert (Al) C. Insurance: Medicare Benefit Integrity, AG-270
PCP: Susan B. Munn, M.D. Referring: Susan B. Munn, M.D.

06/06/2011 Progress Notes: Anthony Godfrey, MD

Reason for Appointment
1. Forms to be filled out for guardianship

History of Present Illness
Interim history:
Mrs. Myers is here today requesting forms to be filled out for permanant guardianship of her son Al.
ELBOW/ARM:
Pt has had rt elbow pain. Had some swelling about a week ago. Mother has been giving him Ibuprofen and applying cold compresses.

Current Medications
Syringes (no needles) Luer Lock 10cc Use with medications
Clonazepam 0.5 mg 1 tablet TID
Granulex Spray apply to heel twice daily
Tegretol 100 mg/5 ml 5 cc QID

Past Medical History
Arthrogryposis
Unilateral partial cleft lip repaired
Bilateral hip dislocation
Club feet
Cerebral palsy
Seizure disorder

Surgical History
club feet repair (bilateral) as infant
cleft lip repair as infant
Feeding tube /1990
Spinal fusion/rods placement

Family History
Father deceased lung cancer
Mother alive

Social History
no Smoking.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Pneumonia (aspiration secondary)

Vital Signs

Wt wc, HR 88/97%, RR 18, BP 126/70.

Physical Examination

Patient has severe scoliosis, protruding tongue, very decreased muscle tone, is nonverbal and in in wheel chair, he is unable to make purposeful movements, but does smile intermittantly duirng interview and exam respodingin in meaningful ways to wait his mother is saying.

Assessments
1. CEREBRAL PALSY NEC - 343.8 (Primary)
2. Grand mal seizures - 345.3

Treatment
1. CEREBRAL PALSY NEC
Medically he is stable. He has had an injury to his right arm recently but today very little evidence is found of this injury. No bruising. No obvious signs of severe pain, but he is s little uncomfortable when I move his arm around.

Follow Up
prn

Electronically signed by Anthony Godfrey on 06/06/2011 at 04:42 PM EDT

Sign off status: Completed

Camden Family Care
1017 Fair St.
Camden, SC 29020
Tel: 803-424-1260
Fax: 803-424-1230



Myers, Albert (Al) C.

33 Y old Male, DOB: 12/04/1977
106 Hunt Cup Lane, Camden, SC-29020
Home: 803-432-0931
Guarantor: Myers, Albert (Al) C. Insurance: Medicare Benefit Integrity
Referring: Susan B. Munn, M.D.

05/16/2011 Progress Notes: Susan B. Munn, M.D.

Reason for Appointment
1. Pressure Sore On Heel

History of Present Illness
Interim history:
Pt here today with pressure sore on (L) heel. Present for a while. Has been using Granulex spray but not healing. Has been trying to keep pressure off his foot.
Will need rx for Tegretol.

Current Medications
Tegretol 100 mg/5 ml 5 cc QID
Syringes (no needles) Luer Lock 10cc Use with medications
Clonazepam 0.5 mg 1 tablet TID
Granulex Spray apply to heel twice daily

Past Medical History
Arthrogryposis
Unilateral partial cleft lip repaired
Bilateral hip dislocation
Club feet
Cerebral palsy
Seizure disorder

Surgical History
club feet repair (bilateral) as infant
cleft lip repair as infant
Feeding tube /1990
Spinal fusion/rods placement

Family History
Father: deceased lung cancer
Mother: alive

Social History
no Smoking.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Pneumonia (aspiration secondary)

Review of Systems
CONSTITUTIONAL:
no weight gain. no loss of appetite. no fever. no weakness. no weight loss.

CARDIOLOGY:
no chest pain, no palpitations, no leg swelling, no dizziness, no shortness of breath.
RESPIRATORY:
no shortness of breath, no chest pain, no chest congestion.
GASTROENTEROLOGY:
no abdominal pain, no nausea, no vomiting, no constipation, no diarrhea, no blood in stool, no change in bowel habits, no heartburn.

Vital Signs
Wt w/c, Temp 98.7 ax, HR 96/98%, BP 100/70.

Physical Examination
GENERAL:
General appearence well nourished, pleasant.
HEART:
PMI normal, non-displaced, rhythm regular, heart sounds normal, no murmur, rubs, or gallops noted.
RESPIRATORY/CHEST:
breath sounds normal, rales no, wheezes no.
ABDOMEN:
guarding no, tenderness no, masses no, liver, spleen not palpable.
EXTREMITIES:
edema no, cyanosis no, tremors no, pulses 2+ bilateral.

Assessments
1. CEREBRAL PALSY NEC - 343.8 (Primary)
2. Grand mal seizures - 345.3
3. Skin ulceration, amebic - 006.6

Treatment
1. Grand mal seizures
Start Tegretol suspension, 100 mg/5 ml, via PEG, 600 cc, 5 cc, QID, 30 days, Refills 6.

2. Skin ulceration, amebic
Probable small pressure ulcer. Discussed padding with mother and caregiver. Will monitor.

Follow Up
prn

Electronically signed by Susan Munn M.D. on 07/21/2011 at 12:32 PM EDT
Sign off status: Completed

Camden Family Care
1617 Fair St.
Camden, SC 29020
Tel: 803-424-1260
Fax: 803-424-1230



Myers, Albert (Al) C.
33 Y old Male, DOB: 12/04/1977
106 Hunt Cup Lane, Camden, SC-29020
Home: 803-432-0931
Guarantor: Myers, Albert (Al) C. Insurance: Medicare Benefit Integrity, AG-270
Referring: Susan B. Munn, M.D.

03/24/2011 Progress Notes: Susan B. Munn, M.D.

Reason for Appointment
1. Refills

History of Present Illness
Interim history:
Pt here today requesting rx for Clonazepam. Tegretol good until August.

Current Medications
Clonazepam 0.5 mg, 1 tablet TID
Tegretol 100 mg/5 ml 5 cc QID
Syringes (no needles) Luer Lock 10cc Use with medications

Past Medical History
Arthrogrypothios
Unilateral partial cleft lip repaired
Bilateral hip dislocation
Club feet
Cerebral palsy
Seizure disorder

Surgical History
club feet repair (bilateral) as infant
cleft lip repair as infant
Feeding tube/1990
Spinal fusion/rods placement

Family History
Father: deceased lung cancer
Mother: alive

Social History
no Smoking.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Pneumonia (aspiration secondary)

Review of Systems

CONSTITUTIONAL:
no weight gain. no loss of appetite. no fever. no weakness. no weight loss.
CARDIOLOGY:
no chest pain. no palpitations. no leg swelling. no dizziness. no shortness of breath.
RESPIRATORY:

no shortness of breath. no chest pain. no chest congestion.
GASTROENTEROLOGY:
no abdominal pain. no nausea. no vomiting. no constipation. no diarrhea. no blood in stool. no change in bowel habits. no heartburn.

Vital Signs
Wt w/c, HR 96, RR 18, BP 104/60.

Physical Examination
GENERAL:
General appearence well nourished, pleasant.
HEART:
PMI normal, non-displaced, rhythm regular, heart sounds normal, no murmur, rubs, or gallops noted.
RESPIRATORY/CHEST:
breath sounds normal, rales no, wheezes no.
ABDOMEN:
guarding no, tenderness no, masses no, liver, spleen not palpable.
EXTREMITIES:
edema no, cyanosis no, tremors no, pulses 2+ bilateral.

Assessments
1. CEREBRAL PALSY NEC - 343.8 (Primary)
2. Grand mal seizures - 345.3
3. Congenital scoliosis - 754.2

Treatment
1. Grand mal seizures
Start Clonazepam, 0.5 mg, PEG, 90, 1 tablet, TID, 30 days, Refills 5

Follow Up
prn

Electronically signed by Susan Mum M.D. on 03/31/2011 at 10:07 AM EDT
Sign off status: Completed

Camden Family Care
1627 Fair St.
Camden, SC 29020
Tel: 803-424-4260
Fax: 803-424-1230



Myers, Albert (Al) C.

33 Y old Male, DOB: 12/04/1977
106 Hunt Cup Lane, Camden, SC-29020
Home: 803-432-0931
Guarantor: Myers, Albert (Al) C. Insurance: Medicare Benefit Integrity, AG-270
PCP: Susan B. Munn, M.D. Referring: Susan B. Munn, M.D.

06/06/2011 Progress Notes: Anthony Godfrey, MD

Reason for Appointment
1. Forms to be filled out for guardianship

History of Present Illness
Interim history:
Mrs. Myers is here today requesting forms to be filled out for permanant guardianship of her son Al.
ELBOW/ARM:
Pt has had rt elbow pain. Had some swelling about a week ago. Mother has been giving him Ibuprofen and applying cold compresses.

Current Medications
Syringes (no needles) Luer Lock 10cc Use with medications
Clonazepam 0.5 mg 1 tablet TID
Granulex Spray apply to heel twice daily
Tegretol 100 mg/5 ml 5 cc QID

Past Medical History
Arthrogrypothies
Unilateral partial cleft lip repaired
Bilateral hip dislocation
Club feet
Cerebral palsy
Seizure disorder

Surgical History
club feet repair (bilateral) as infant
cleft lip repair as infant
Feeding tube /1990
Spinal fusion/rods placement

Family History
Father: deceased lung cancer
Mother: alive

Social History
no Smoking.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Pneumonia (aspiration secondary)

Vital Signs

Wt wc, HR 88/97%, RR 18, BP 126/70.

Physical Examination

Patient has severe scoliosis, protruding tongue, very decreased muscle tone. is nonverbal and in in wheel chair, he is unable to make purposeful movements, but does smile intermittantly duirng interview and exam respodingin in meaningful ways to wait his mother is saying. .

Assessments

1. CEREBRAL PALSY NEC - 343.8 (Primary)
2. Grand mal seizures - 345.3

Treatment

1. CEREBRAL PALSY NEC

Medically he is stable. He has had an injury to his right arm recently but today very little evidence is found of this injury. No bruising. No obvious signs of severe pain, but he is s little uncomfortable when I move his arm around.

Follow Up

prn

Electronically signed by Anthony Godfrey on 06/06/2011 at 04:42 PM EDT

Sign off status: Completed

Camden Family Care
1017 Fair St.
Camden, SC 29020
Tel: 803-424-1260
Fax: 803-424-1230



Myers, Albert (Al) C.
33 Y old Male, DOB: 12/04/1977
106 Hunt Cup Lane, Camden, SC-29020
Home: 803-432-0931
Guarantor: Myers, Albert (Al) C. Insurance: Medicare
Benefit Integrity
Referring: Susan B. Munn, M.D.

05/16/2011

Progress Notes: Susan B. Munn, M.D.

Reason for Appointment
1. Pressure Sore On Heel

History of Present Illness
Interim history:
Pt here today with pressure sore on (L) heel. Present for a while. Has been using Granulex spray but not healing. Has been trying to keep pressure off his foot.
Will need rx for Tegretol.

Current Medications
Tegretol 100 mg/5 ml 5 cc QID
Syringes (no needles) Luer-Lock 10cc Use with medications
Clonazepam 0.5 mg 1 tablet TID
Granulex Spray apply to heel twice daily

Past Medical History
Arthrogrypothics
Unilateral partial cleft lip repaired
Bilateral hip dislocation
Club feet
Cerebral palsy
Seizure disorder

Surgical History
club feet repair (bilateral) as infant
cleft lip repair as infant
Feeding tube /1990
Spinal fusion/rods placement

Family History
Father: deceased lung cancer
Mother: alive

Social History
no Smoking.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Pneumonia (aspiration secondary)

Review of Systems

CONSTITUTIONAL:
no weight gain. no loss of appetite. no fever. no weakness. no weight loss.

CARDIOLOGY:
no chest pain. no palpitations. no leg swelling. no dizziness. no shortness of breath.
RESPIRATORY:
no shortness of breath. no chest pain. no chest congestion.
GASTROENTEROLOGY:
no abdominal pain. no nausea. no vomiting. no constipation. no diarrhea. no blood in stool. no change in bowel habits. no heartburn.

Vital Signs
Wt w/c, Temp 98.7 ax, HR 96/96%, BP 100/70.

Physical Examination
GENERAL:
General appearence well nourished, pleasant.
HEART:
PMI normal, non-displaced. rhythm regular. heart sounds normal, no murmur, rubs, or gallops noted.
RESPIRATORY/CHEST:
breath sounds normal. rales no. wheezes no.
ABDOMEN:
guarding no. tenderness no. masses no. liver, spleen not palpable.
EXTREMITIES:
edema no. cyanosis no. tremors no. pulses 2+ bilateral.

Assessments
1. CEREBRAL PALSY NEC - 343.8 (Primary)
2. Grand mal seizures - 345.3
3. Skin ulceration, amebic - 006.6

Treatment
1. Grand mal seizures
Start Tegretol suspension, 100 mg/5 ml, via PEG, 600 cc, 5 cc, QID, 30 days, Refills 5

2. Skin ulceration, amebic
Probable small pressure ulcer. Discussed padding with mother and caregiver. Will monitor.

Follow Up
prn

Electronically signed by Susan Munn M.D. on 07/21/2011 at 12:32 PM EDT
Sign off status: Completed

Camden Family Care
1017 Fair St.
Camden, SC 29020
Tel: 803-424-1260
Fax: 803-424-1230



Myers, Albert (Al) C.

33 Y old Male, DOB: 12/04/1977
106 Hunt Cup Lane, Camden, SC-29020
Home: 803-432-0931
Guarantor: Myers, Albert (Al) C. Insurance: Medicare Benefit Integrity, AG-270
Referring: Susan B. Munn, M.D.

03/24/2011 Progress Notes: Susan B. Munn, M.D.

Reason for Appointment
1. Refills

History of Present Illness
Interim history:
Pt here today requesting rx for Clonazepam. Tegretol good until August.

Current Medications
Clonazepam 0.5 mg 1 tablet TID
Tegretol 100 mg/5 ml 5 cc QID
Syringes (no needles) Lure Lock 10cc Use with medications

Past Medical History
Arthrogrypothics
Unilateral partial cleft lip repaired
Bilateral hip dislocation.
Club feet
Cerebral palsy
Seizure disorder

Surgical History
club feet repair (bilateral) as infant
cleft lip repair as infant
Feeding tube /1990
Spinal fusion/rods placement

Family History
Father: deceased lung cancer
Mother: alive

Social History
no Smoking.
no Alcohol.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
Pneumonia (aspiration secondary)

Review of Systems

CONSTITUTIONAL:
no weight gain. no loss of appetite. no fever. no weakness. no weight loss.
CARDIOLOGY:
no chest pain. no palpitations. no leg swelling. no dizziness. no shortness of breath.
RESPIRATORY:

no shortness of breath. no chest pain. no chest congestion.
GASTROENTEROLOGY:
no abdominal pain. no nausea. no vomiting. no constipation. no diarrhea. no blood in stool. no change in bowel habits. no heartburn.

Vital Signs
Wt w/c, HR 96, RR 18, BP 104/60.

Physical Examination
GENERAL:
General appearence well nourished, pleasant.
HEART:
PMI normal, non-displaced. rhythm regular. heart sounds normal, no murmur, rubs, or gallops noted.
RESPIRATORY/CHEST:
breath sounds normal. rales no. wheezes no.
ABDOMEN:
guarding no. tenderness no. masses no. liver, spleen not palpable.
EXTREMITIES:
edema no. cyanosis no. tremors no. pulses 2+ bilateral.

Assessments
1. CEREBRAL PALSY NEC - 343.8 (Primary)
2. Grand mal seizures - 345.3
3. Congenital scoliosis - 754.2

Treatment
1. Grand mal seizures
Start Clonazepam, 0.5 mg, PEG, 90, 1 tablet, TID, 30 days, Refills 5

Follow Up
prn

Electronically signed by Susan Mumm M.D. on 03/31/2011 at 10:07 AM EDT
Sign off status: Completed

Camden Family Care
1017 Fair St.
Camden, SC 29020
Tel: 803-424-1260
Fax: 803-424-1230

Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
V/TTY: 803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

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Susan K. Lait
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December 1, 2009

Dear Mental Retardation/Related Disabilities (MR/RD) Waiver Participant and Family Members:

The Centers for Medicare and Medicaid Services (CMS) has approved changes to the MR/RD Waiver. These changes will go into effect January 1, 2010 and will likely affect you. The changes are:

- The following services are being *eliminated* since they are covered under regular Medicaid:
  - Physical Therapy;
  - Occupational Therapy; and,
  - Speech/Language Pathology.
- Daily respite is replaced by hourly respite.
- Day Habilitation, Prevocation, and Supported Employment are being replaced by Day Activity, Community Services, Support Center, Career Preparation, and Employment.
- Service use caps are being placed on the following services:
  - Adult Companion – capped at a maximum of 28 hour per week (Adult means 21 years of age or older).
  - Adult Attendant – capped at a maximum of 28 hour per week (Adult means 21 years of age or older).
  - Personal Care II – capped at a maximum of 28 hour per week.

The waiver participant may use a single service or combine Adult Companion, Adult Attendant, and Personal Care II Services. The single service or any combination of the three (3) services cannot exceed 28 hours per week.

Box 239
ton, SC 29325-5328
ne: (864) 938-3497

DISTRICT I
Midlands Center - Phone: 803/93
Whitten Center - Phone: 864/83

Road
485
Phone: 843/832-5576.

DISTRICT II
Coastal Center - Phone: 843/873-5750
Pee Dee Center - Phone: 843/664-2600
Saleeby Center - Phone: 843/332-4104

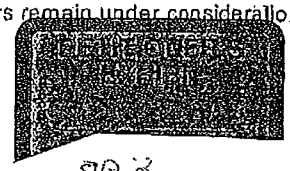
89-1

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

Peter B., Jimmy "Chip" E. and Michelle M.,	)	Civil Action No. 6:10-767-JMC-BHH
Plaintiff,	)	
vs.	)	
Marshall C. Sanford, Emma Forkner, Beverly Buscemi, Kelly Floyd, The South Carolina Department of Health and Human Services and The South Carolina Department of Disabilities and Special Needs,	)	REPORT AND RECOMMENDATION OF MAGISTRATE JUDGE
Defendants.	)	

The plaintiffs have brought this action seeking declaratory and injunctive relief for violation of Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12132; Section 504 of the Rehabilitation Act of 1973 (Section 54); and 42 U.S.C. § 1983. This matter is before the Court on the plaintiffs' motion for injunctive relief pursuant to Fed. R. Civ. P. 65(b).[1] [Doc. 12.] The defendants have filed numerous responses [Docs. 18, 19, 28, 47, 70], and the plaintiffs have replied [Doc 44]. The plaintiffs ask the Court to enjoin the defendants from reducing or terminating certain medical and personal care services, the absence of which would allegedly force the plaintiffs from their homes and communities into disability institutions and other like facilities. In addition to the full briefing of the parties, the

[1] There is also a motion to dismiss and a motion to amend Complaint pending in this case. Those outstanding matters remain under consideration and will be resolved shortly.



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Court allowed and considered the *amici curiae* brief filed by Protection and Advocacy for People with Disabilities, Inc., the South Carolina Chapter of the National Academy of Elder Law Attorneys, and South Carolina Legal Services in support of the plaintiffs' motion. Moreover, a hearing on the motion was held before the Court, on September 28, 2010.

Based upon the parties' respective representations at both hearing and on motion, the Court has allowed this case some opportunity to be resolved through changed circumstances at the state level. [Doc. 28.] It has become apparent over time that a resolution is now in order.

BACKGROUND

The plaintiffs are three individuals who have varying degrees of severe mental retardation and/or related disabilities. Peter B. has mental retardation, hydrocephalus, diabetes and coronary heart disease. (See Pl. Exs. 1, 3.) Chip E. has normal intelligence and severe cerebral palsy and a speech disorder. (See Pl. Ex. 9.) Michelle M. has autism, profound mental retardation, cerebral palsy, a bipolar disorder and is unable to speak. (See Pl. Ex. 4.)

The defendant South Carolina Department of Disabilities and Special Needs ("DDSN") provides services to individuals, like the plaintiffs, with developmental disabilities such as mental retardation and autism, and to some individuals with head and spinal cord injuries. *See* S.C. Code § 44-21-10 *et seq.* The vast majority of DDSN's funding derives from the federal Medicaid program, passed through to DDSN from the state Medicaid agency, defendant South Carolina Department of Health and Human Services ("DHHS").

id. Some of the settings are homes owned or rented by the individual or a family member. Individuals, who live in their own home or the home of a friend or family member, receive a variety of services to meet their care needs.

In late 2009, DHHS, which is the single state agency responsible for the Medicaid program, sought and received the approval of the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) to amend the waiver to limit or cap certain services. (Def. Ex. 3, Attach A.) The defendants represent that the amendments to the waiver were born out of the indisputably difficult economic climate of severe state budget reductions and further were intended to eliminate disparities between people with similar disability needs and to reduce superfluous and redundant services. (Forkner Aff. ¶ 5-7.) Effective as of January 1, 2010, the amended waiver placed a service use cap, or flat cap, on the number of hours an individual could receive for particular services: Personal Care I and II, Adult Attendant Care, Adult Companion Care, Nursing, and in-home Respite services. *Id.*

The summary of the capped services, relevant here, are as follows: Personal Care II services were capped at 28 hours per week, or four hours per day. Respite services were also capped, at 68 hours per month, or slightly over two hours per day.

Importantly, these caps affected two of the plaintiffs, Chip E. and Michelle M. (Lacy Aff. at 3-5.) The precise kind and level of services provided each of the plaintiffs both prior to, and after, the waiver amendments has been the source of some disagreement between the parties and the subject of numerous and disparate representations in declarations and

briefs of the same. Corralling the data has been less than a straight-forward process. This is the Court's best estimation and summary of the evidence, concerning each plaintiff respectively.

Jimmy (Chip) E.

Service	Before 1/1/2010	After 1/1/2010 (proposed/actual)
Personal Care II	52 hours per week	28 hours per week
In-home Respite	112 hours per month	68 hours per month

(Pl. Reply at 6-8, Attach. 1 at 22, 37, 47, 49, 51, Attach. 12.)

Michelle M.

Service	Before 1/1/2010	After 1/1/2010 (proposed/actual)
Personal Care II	56 hours per week	28 hours per week
In-home Respite	28 hours per week[2]	30 hours per week
Institutional respite[3]	0	0

(Pl. Reply at 11, Attach. 4 at 81, 93, 95.)

Much energy could be devoted to outlining the services allegedly now available to the plaintiffs and the ostensible alternatives, available or not, depending on the arguments

[2] The defendants put forward evidence that the plaintiff had up to 240 hours per month. (See Lacy Aff.) The plaintiffs have responded that she was never provided that many hours and that the 30 hours per week allotted in May 2010, was an increase of only 2 hours. (Pl. Reply at 11, Attach. 4 at 81.)

[3] The defendants originally submitted testimony that she was provided 2 weeks of institutional respite per year. The plaintiffs have rejoined that no such service has ever been available. (Pl. Reply, Attach. 4 at 81.)

of the parties. The plaintiffs have done a persuasive job of establishing the hours they have received and the defendants, aside from their original representations, have done little to effectively counter, either in their filings or at hearing. The Court, therefore, has largely adopted the plaintiffs' evidence concerning services and hours provided, whether discussed specifically herein or not. To the Court, it is sufficient to say that there has been a diminution in service hours for both Chip and Michelle, which, as will be discussed, their treating physicians find significant. More to the point, it is this reduction in hours that the plaintiffs contend will drive them to an institution against their will and hope and in violation of the Americans with Disabilities Act.

The third plaintiff, Peter B., receives services in a DDSN residential placement, as part of a Supervised Living Program II (SLP II). The care needs for individuals in DDSN residential placements are met through the residential habilitation service, during periods of the day when the individual is receiving residential habilitation services. For example, if individuals receiving residential habilitation need assistance with their meals, then the residential habilitation provider is responsible for seeing the need is met. (See Lacy Aff. at 2 & Attach. B.) Those, like Peter, receiving residential habilitation have not had caps placed on the number of hours of Personal Care they can receive, unlike those individuals who live in their own homes. *See id.*; Attach. A. However, Peter contends that 12 hours of "one-on-one" services were terminated as duplicative and not covered by Medicaid. (See generally Lucy Aff. at 2-3.) The termination of those services occurred in July 2009. *Id.* Like Michelle and Chip, Peter contends that the elimination of these services will effectively result in

forced and undesired institutionalization.

Lastly, the Court would acknowledge that the plaintiffs have commenced administrative actions concerning these same services, which are at varying stages of resolution. Most notably, it appears that Peter's appeals have been denied. [See Doc. 70.] The Court will address the effect of these proceedings to the extent relevant, but, as will be discussed, finds them to be largely non-dispositive or otherwise non-preclusive of this Court's consideration.

DISCUSSION

This is a fact intensive and messy case. From its procedural and statutory dimensions to its medical ones, it is substantial. In its review, the Court has attempted to narrow the necessary attention to be applied. Of course, the individual circumstances and incidents of the plaintiffs' particularized needs tend to additionally layer the inquiry. The whole thing is a delicate matter and, certainly for the plaintiffs, much would seem to hang in the balance. They have an unquestionably powerful story, which has moved the undersigned, in sympathy, if not in the specific formation of this decision's many contours. Sympathetic considerations, however, are largely outside this Court's purview. As always, there is a legally correct answer to the dilemma posed, which this recommendation attempts to approximate, in general result if not perfect detail. The care the plaintiffs require is complicated, burdensome, and inexact. In some respects, there is no easy answer to their situations. But certainly, if anyone knows what might be the best, among many less than perfect alternatives, it is the plaintiffs, their families, and their physicians. To credit those

accounts, earnestly, seems in keeping with the manner in which these cases are to be considered. *See Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring) ("The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.") The defendants do much good for the disabled persons of our larger community and the Court is aware of the appropriate bases, economic and otherwise, which have motivated the decisions at issue here on behalf of a much larger populace than the individuals prosecuting this case. With that said, and based on the following, as considered in light of the hearing, both in its argument and evidence, and the many briefs of the parties and *amici*, the Court has concluded that a preliminary injunction should lie.

"A preliminary injunction is an extraordinary and drastic remedy." *Munaf v. Geren*, 553 U.S. 674, 128 (2008) (internal quotations omitted). Rule 65 of the Federal Rules of Civil Procedure governs the issuance of Preliminary Injunctions. Pursuant to Rule 65, "a temporary restraining order may be granted . . . only if it clearly appears from specific facts shown . . . that immediate and irreparable injury, loss, or damage will result to the applicant." In its recent opinion in *Winter v. Natural Resources Defense Council, Inc.*, 129 S.Ct. 365, 374-76 (2008), the United States Supreme Court articulated clearly what must be shown to obtain a preliminary injunction, stating that the plaintiff must establish "[1] that he is likely to succeed on the merits, [2] that he is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in his favor, and [4] that an injunction is in the public interest." *Id.* at 374. Critically, all four requirements must be satisfied. *Id.*

Indeed, the Supreme Court in *Winter* rejected a standard that allowed the plaintiff to demonstrate only a "possibility" of irreparable harm because that standard was "inconsistent with our characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Id.* at 375-76.

Before the Supreme Court's decision in *Winter*, the standard articulated in *Blackwelder Furniture Co. of Statesville v. Sellig Manufacturing Co.*, 550 F.2d 189 (4th Cir.1977), governed the grant or denial of preliminary injunctions in the Fourth Circuit. *See Direx Israel, Ltd. v. Breakthrough Med. Corp.*, 952 F.2d 802, 811-14 (4th Cir.1991); *Rum Creek Coal Sales, Inc. v. Caperton*, 926 F.2d 353, 359-60 (4th Cir.1991);

In *Real Truth About Obama, Inc. v. Federal Election Com'n*, 2009 WL 2408735 (4th Cir. August 5, 2009), the Fourth Circuit expressly concluded that the *Blackwelder* standard stood "in fatal tension with the Supreme Court's 2008 decision in *Winter*." *Id.* at *3. That decision, however, was vacated by the United States Supreme Court for reasons unrelated to the Fourth Circuit's discussion concerning preliminary injunctions. *See Real Truth About Obama, Inc. v. Federal Election*, 130 S. Ct. 2371, 2371 (U.S. 2010) (vacating and remanding for further consideration in light of *Citizens United v. Federal Election Com'n*, 130 S.Ct. 876 (U.S. 2010)).

It seems that the vacated Fourth Circuit decision still remains some good indication of how this Circuit would view application of *Winter*. In *Real Truth* the Fourth Circuit, stated that a plaintiff must now show that he will "likely succeed on the merits" regardless of whether the balance of hardships weighs in his favor. *Id.* Moreover, the standard for

likelihood of success on the merits requires more than simply showing that "grave or serious questions are presented" for litigation. *Id.* Second, the plaintiff must make a clear showing that he will likely be irreparably harmed absent preliminary relief. *Id.* That the plaintiff's harm might simply outweigh the defendant's is no longer sufficient. *Id.* Moreover, this showing of irreparable injury is mandatory even if the plaintiff has already demonstrated a strong showing on the probability of success on the merits. *Id.* Third, the Court is admonished to pay "particular regard" to the "public consequences" of any relief granted. *Id.* Lastly, there no longer exists any flexible interplay between the factors; all four elements of the test must be satisfied. *Id.* A failure to establish any of the elements necessary for relief is, therefore, fatal to the request for a temporary restraining order. *Winter*, 129 S.Ct. at 374.

Applying the standard in *Winters*, the Court finds that the plaintiffs have established entitlement to a preliminary injunction. Each element will be considered in turn.

Likelihood of Success on the Merits

Title II of the Americans with Disabilities Act of 1990 (ADA), prohibits discrimination by public entities against individuals with disabilities. *See* 42 U.S.C. § 12132. The United States Supreme Court has held that prohibited discrimination under the ADA includes "unnecessary segregation" and "unjustified institutional isolation of personal disabilities." *Olmstead v. L.C.*, 527 U.S. 581, 600-02 (1999). The Supreme Court's determination was based, in part, on the Department of Justice regulation, usually referred to as the "integration mandate," which requires states to administer services "in the most integrated

setting appropriate to the needs of the qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (amended at 75 F.R. 56164-01, adding a section "h" to § 35.130). The most integrated setting appropriate is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." *Olmstead*, 527 U.S. 581, 592 (citing 28 C.F.R. pt. 35, App. A. p. 450, redesignated App. B at 75 F.R. 56164-01). In other words, it is discrimination, on account of a person's disability, to create obstacles to their ability to live normally in their community.

In *Olmstead v. L.C.*, the United States Supreme Court found a violation of the ADA, ruling in favor of disabled individuals seeking to reside in the community, rather than in a segregated facility. *Olmstead*, 527 U.S. at 607. The Court emphasized the Preamble of the ADA and the accompanying Congressional finding that "society has tended to isolate and segregate individuals with disabilities" and that the issue continues to be a "serious and pervasive social problem." *Id.* at 600. The Court held that the integration mandate of the ADA governed the plaintiffs' claims. *See Olmstead*, 527 U.S. at 588.

> States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

Id. at 607.

To state a claim under Title II of the ADA based on a violation of the integration mandate, the plaintiff must prove that (1) the State's treatment professionals have

determined that community-based services are appropriate; (2) the disabled individual does not oppose treatment; and (3) the provision of community-based services can be reasonably accommodated, taking into account the resources available to the state and the needs of other disabled individuals.[4] *Olmstead*, 527 U.S. at 587. Critically, a State's failure to provide services to a qualified person in a community-based setting as opposed to a nursing home or institution presents a violation of Title II of the ADA. *See id.*; *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1181-82 (10th Cir. 2003) (imposition of cap on prescription medications placed on participants in community-based program at high risk for premature entry into nursing homes in violation of the ADA).

At this juncture, the plaintiffs have presented evidence demonstrating that their services are being terminated by defendants in violation of the ADA sufficient to justify interim equitable relief. The defendants, focused almost exclusively on the irreperability of the harm alleged, have not really made much argument regarding the plaintiff's likelihood of success on the merits. The Court will consider each element of the substantive claim, in turn.

In regards to the first, there is no dispute between the parties that the plaintiffs, who have been successfully living in their own homes for numerous years, are deemed eligible for community-based living by the State's experts. Concerning the second element, the

[4] Under the specific paradigm of the ADA, the elements of the claim have been articulated as follows: (1) is a "qualified individual with a disability;" (2) was either excluded from participation in or denied the benefits of a public entity's services, programs, or activities or was otherwise discriminated against by the public entity; and (3) such exclusion, denial of benefits, or discrimination was by reason of his disability. *See Townsend v. Quasim*, 328 F.3d 511, 517 (9th Cir. 2003).

very existence of this lawsuit, and every representation of the plaintiffs made herein, attests to a complete lack of any objection to community-based living; that is their plain and affirmative desire – to live in their communities.

Lastly, whether the provision of community-based services can be reasonably accommodated, taking into account the resources available to the State and the needs of other disabled individuals, the plaintiffs have put forward evidence that in all material respects it is less costly to provide the community-based, in-home services than institutional ones. (Compare Pl. Ex. 10 with Ex. 11.) To wit, capped respite services for Michelle M. were enjoyed at a cost of $70/day compared with the alternative provision of those same services in an institution at $320/day. (Pl. Exs. 4, 5, 23.) Likewise, the record reveals that Peter B.'s requested one-on-one companion services cost less than $200/week before their elimination under the amendments and that the alternative offer by the state to enroll him in a Workability workshop would cost more than $220/week.[5] (Pl. Ex. 1 at 4.) Similarly, the services Chip E. has been receiving during 2010 cost $39,424.25, approximately one-third of the cost of institutional services. [See Doc. 44-10 at 269.] The same institutional services would cost approximately $116,000.00 a year. [See Doc. 44-11.] As to all potential disabled persons affected by the amendments, the plaintiffs have put forward evidence that the number of waiver participants and the likely length of time for such participants in institutional facilities would increase, with a concomitant increase in overall and service-

[5] These figures were represented by the plaintiffs to the Court. Their exact source is not clear. Regardless, the record does, in the least, admit to a greater cost for alternative services than the ones requested by Peter B. (Pl. Ex. 1 at 4.)

specific costs. (Compare Pl. Ex. 10 with Ex. 11.)

Olmstead, instructs that the State is exempted from the integration mandate only where a "fundamental alteration" of the States' services or programs is required. *Olmstead*, 527 U.S. at 591-92. Not only do the plaintiff's not request any alteration, fundamental or otherwise, but they beg for a returned *status quo*, which is apparently cheaper for the State, and better for the individuals, than the amendments. The Court cannot understand, and the defendants have not explained, how the requested community-based services could be "reasonably accommodated" any better. *See Olmstead*, 527 U.S. at 587.

The defendants' only real rejoinder is that, as of this moment, actual institutionalization of the plaintiffs has not occurred and that there exists no credible risk of it, such that any argument concerning cost differential is effectively speculative and premature. The argument seems simultaneously to go to the merits consideration and the irreparability of the harm alleged. The defendant argues it as to the latter. The Court will make some comment in both sections, but principally, here, under the merits analysis.

To echo the briefs of the plaintiffs and the *amici*, cases involving ADA integration claims have consistently recognized that even *the risk* of institutionalization is sufficient to establish a violation of Title II and certainly to justify preliminary relief. *See Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1184 (10th 2003) (holding that Medicaid participants not currently institutionalized but at "high risk for premature entry into a nursing home" could bring claim for violation of the integration mandate); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161, (N.D. Cal. 2009); *Mental Disability Law Clinic v. Hogan*, 2008 WL

4104460, at *15 (E.D.N.Y. Aug. 28, 2008) (stating "even the risk of unjustified segregation may be sufficient under *Olmstead*"). The case law is clear that plaintiffs need not wait to be institutionalized before relief is sought.

Illustratively, the Eastern District of North Carolina recently granted emergency injunctive relief, prohibiting the State from reducing home-based services to persons who had a dual diagnosis of mental retardation and mental illness, just three days after the plaintiffs in that case filed their complaint alleging violation of the ADA; there, the plaintiffs were at risk of having to move from independent apartments to group home or institutional facilities. *See Marlo M. v. Cansler*, 679 F. Supp. 2d 635 (E.D.N.C. Jan. 17, 2010). While the plaintiffs had not been institutionalized at the time of the filing of the complaint, the district court concluded that a likelihood of success on the merits existed because the plaintiffs had shown that the State's termination of funding *threatened* to force the plaintiff's from their then present living situations into group homes or institutional settings. *Id.* at 638; *see also Ball v. Rogers*, 2009 WL 1395423, at *5 (D. Ariz. April 24, 2009) (holding that failure to provide plaintiffs with needed services threatened plaintiffs with institutionalization, prevented them from leaving institutions, and in some instances forced them into institutions in order to receive their necessary care in violation of the ADA and Rehabilitation Act); *Hogan*, 2008 WL 4104460, at *15 ("[E]ven the risk of unjustified segregation may be sufficient under Olmstead"); *M.A.C. v. Betit*, 284 F.Supp. 2d 1298, 1309 (D. Utah 2003) (adopting *Fisher's* position that a plaintiff need not currently be institutionalized to bring suit).

Specifically, here, the plaintiffs have put forward the following evidence concerning

the risk of institutionalization posed by the elimination of various services. Concerning Peter B., his treating physician has documented Peter's physical and psychological deterioration since the elimination of the requested services (Reel Aff. ¶ 7-9) and has expressed the opinion that "if the services are not restored, Peter risks loss of the ability to live independently in a community setting and he will likely be placed in an institutional setting because of a decline in his physical and mental condition," *Id.* ¶ 10. Likewise, Michelle M.'s treating physician, based upon Michelle's parents inability to assist and here, otherwise, absolute reliance on in-home services to keep her out of a facility, has further indicated that if relevant services were reduced, "Michelle would be likely to have to return to an institution." (Patterson Aff. ¶¶ 9, 10.) Chip E.'s treating physician has made comparable representations. [See generally Doc. 44-2.] These opinions have been given significant weight. *See Olmstead*, 527 U.S. at 610; *Crabtree v. Goetz*, 2008 WL 5330506, at *25 (M.D. Tenn. Dec. 19, 2008).

The defendants contend that the claim of Peter B.'s particular demand is betrayed insofar as he has been without the requested services since July 2009 and, yet, no institutionalization has been required. But, this is not conflicting medical testimony. Rather, it is an unsupported attempt to correlate the two events. The defendants cite administrative findings that the plaintiff has not met his burden to associate his weight loss with the diminution in one-on-one services. (Def. Resp. at 14.) But, besides the irrelevancy of the administrative conclusion regarding evidence which may or may not now be before this Court, Peter has, in fact, submitted evidence, here, that his weight loss is so related; that

it will dangerously affect his diabetes; and that those conditions will force institutionalization. (Reel Aff. ¶ 7-10.) The defendants have offered some evidence of Peter's fluctuating weight over the years. (Moore Aff. ¶ 4.) But, this does not precisely refute the opinion of Peter's treating physician that Peter's condition will continue to deteriorate such that institutionalization is inevitable. (Reel Aff, ¶ 7-9.) That evidence is uncontradicted. And, the Court would credit it.

The defendants further argue that the plaintiffs' claims are not "ripe" because SCDDSN has agreed to provide services at current levels to Michelle M. and Chip E. while their administrative appeals are pending in the South Carolina Administrative Law Court. It is true that federal courts may issue declaratory judgments only in cases of actual controversy. 28 U.S.C. § 2201. The defendants emphasize that the controversy must be "ripe" for judicial resolution, and that in the context of an administrative case, there must be "an administrative decision [that] has been formalized and its effects felt in a concrete way by the challenging parties." *Charter Federal Sav. Bank v. Office of Thrift*, 976 F.2d 203, 208 (4th Cir. 1992). In a similar South Carolina ADA/Medicaid decision, however, the United States Court of Appeals for the Fourth Circuit expressly indicated that the administrative proceedings pending in the State courts were irrelevant to the federal claims. *See Doe v. Kidd*, 501 F.3d 348, 353 n.1 (4th Cir. 2007). The court stated:

> There have been state administrative proceedings in Doe's case since she noted her appeal to this Court. We do not consider the outcome of these proceedings because the outcome has no effect, preclusive or otherwise, on the issues Doe raises before this Court.

Id.

Moreover, in this case, the "formalized" administrative decision is the January amendments themselves, which of their own force exercise legal and binding effect over the plaintiff's circumstances. *See Abbott Laboratories v. Gardner*, 387 U.S. 136, 149-50 (1967) (finding regulations themselves to be "final agency action"), *overruled on other grounds by Califano v. Sanders*, 430 U.S. 99 (1977)). The fact that the plaintiffs have challenged the amendments' specific application in the form of an administrative appeal, in addition to the judicial case here, does not make the actual regulatory amendments any less "formalized." The amendments were effective as of January 1, 2010, and there was no act of an administrative court necessary to formalize them any further. And certainly, the defendants cannot expect the plaintiffs, psychologically frail in the first instance, to rely on the vagaries of a promise that services will continue during the pendency of appeal. This lawsuit is their right, as far as the Court can tell.

The plaintiffs have met the burden to establish the three elements of their ADA integration claim. The Court would recommend, therefore, that the plaintiffs have shown a likelihood of success on the merits.[6]

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[6] The Court has had some concern over the objection of the defendants that the one-on-one services requested by Peter B. are not properly allowable Medicaid services. Frankly, the defense has not been thoroughly briefed. As far as the Court can tell, the issue in the State administrative proceedings has largely turned on the perceived duplicative nature of those services to other services. [Docs. 19-1, 70-1, -2; Lacy Aff. at 2.] As to that point, the defendants' showing here is unavailing. The plaintiffs have submitted evidence that the one-on-one services are essential and not redundant. (See Reel Aff. ¶¶ 7-10.) It is true that the administrative law court appears to have agreed that the services were non-waiver services [Doc. 19-1], but the Court does not believe, and the defendants have not argued, that that determination is somehow binding here. Moreover, the adjudication that the services are non-waiver in quality does not appear to be dispositive. As the *amici* explains, the waiver program is merely an optional tool, which states can use to provide

Irreparable Harm

The evidence at this point is strong that the plaintiffs will suffer regressive consequences if moved, even temporarily. The plaintiffs have behavioral and special needs, and benefit from a stable environment and personalized treatment. Information in the record indicates that they each have conditions or behaviors which make them poor candidates for group housing.

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

---

services in the community and to save money on providing institutional care. In other words, use of waivers is simply one way a state may meet the integration mandate of the ADA. "Medicaid can be an important resource to assist states in fulfilling their obligations under ADA. The [Home and Community-Based Services (HCBS)] waiver program in particular is a viable option for states to use to provide integrated community-based long-term care services and supports to qualified Medicaid eligible recipients." HCBS Waivers – 1915(c), at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915%28c%29.asp (last viewed Nov. 22, 2010). In other words, the status of the one-on-one services as non-waiver does not seem to absolve the defendants of their obligation to provide services to the plaintiff, which would keep in him the community as mandated by *Olmstead*. Again, the issue has been thinly treated and may be better traced at a later procedural moment in this case. For now, the Court has no reason to conclude either that the one-on-one services are non-waiver or, to the extent that they are, that such a determination matters.

would irreparably harm plaintiffs). In other words, institutionalization, as a result of a denial of benefits, constitutes, legally speaking, the kind of harm which equitable relief is suited to enjoin.

More concretely, the plaintiffs have put forward evidence, specifically, of the kind of injury they would face. As discussed, the decline in Peter B.'s mental and physical condition since the termination of his companion services has already been documented. (Pl. Exs. 1, 3, 14.) Soon after Peter B.'s companion services were terminated, his anxiety and depression increased. (See Pl. Exs. 1, 14.) He lost nine pounds between the time that his companion services were terminated and the filing of this lawsuit. *Id.* This physical deterioration is likely to exacerbate his diabetic condition without the supervision of his specialized diet and exercise provided by his companion service provider. (Reel Aff. ¶ 7-10.) Peter's behavior support specialist and psychological services provider, Lennie Mullis, has indicated that Peter's ability to maintain employment, predicated on community living, is essential to his personal identity and mental health. (Mullis Aff. at 2.) The deterioration in his health, as previously cited, will jeopardize his ability to work, which will lead to both "depression and withdrawal." *Id.* at 2-3.

The plaintiffs have also put forward evidence that Michelle M. is likely to suffer the same unexplained physical injuries she experienced when she was previously institutionalized. (Pl. Exs. 4, 5.) There, she mysteriously fell, resulting in the loss of teeth; was clawed on her neck and side to the point of scarring; broke her toe; fell into depression; lost weight; and had difficulty sleeping. (Pl. Ex. 4 ¶¶ 14-19.) The plaintiffs have offered

evidence that she would be at risk of choking from aspiration due to the elimination of speech and language services. (Pl. Ex 5.) In a congregate setting, there is evidence that Michelle M. will be at risk for infections, particularly of her stoma where she is fed through a tube into her stomach. (Pl. Exs. 5, 14.) It has been represented, and unrefuted, that Michelle M. pulls out her feeding tube when she tries to stand up while being fed. (Pl. Ex. 14.) She will likely have to be restrained in a chair if she is placed in an institution. Lastly, because of Michelle M.'s behavioral issues and loud outbursts, she is at great risk in a congregate setting of abuse by other residents, as well as by frustrated and frequently poorly trained staff members. (Pl. Exs. 5, 14.) These are not compensable injuries.

Lastly, the threat of irreparable injury to Chip E. is slightly more difficult to summarize. He is the highest functioning of the three plaintiffs and, maybe, precisely for this reason, the prospect of institutionalization is most terrorizing to him. (Pl. Ex. 9 ¶ 12.) The threat of irreparable injury to Chip exists exactly in the lost opportunity that community living offers. The evidence reveals that Chip is significantly involved with the Clinton High School Football team in substantive ways, all of which would be forfeited upon institutionalization. (Chip Aff. ¶6 .) This is precisely the sort of injury incidental to the prejudice of segregation, which the *Olmstead* mandate contemplates and seeks to redress. *See Olmstead*, 527 U.S. at 600-01 ("[C]onfinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.") His experience in an institution would come with all of the adjunct humiliations that violation of personal space

and person imposes. "Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* Where such an experience can be avoided, without significant alteration of the *status quo*, the United States Supreme Court has stated, it should be.

The Court does not mean to insult the hard work of the defendants or the individual care providers that accomplish it, but it would be an oversight of this decision not to also emphasize the fairly serious deficiencies of various institutional facilities, revealed in a state agency audit, which include unsanitary conditions; abuse; neglect; and exploitation. [Doc. 44-10 at , 287, 308-09.] Institutions can be places of both great compassion and unspeakable horror. These are not insignificant considerations when measuring the irreparable harm and opportunity cost of a *de facto* involuntary institutionalization of a person otherwise content and healthy in community.

These various forms of psychological and physical harms posed by institutionalization have been recognized as irreparable and sufficient to justify injunctive relief. *See Marlo*, 2010 WL 148849, at *2; *Crabtree v. Goetz*, 2008 WL 5330506, at *30 (M.D. Tenn. Dec., 19, 2008). The Court would agree, on the record here. The cited opinions of the plaintiffs' treating physicians, which are entitled to deference, *see Olmstead*, 527 U.S. at 610; *Crabtree*, 2008 WL 5330506, at *25, create more than a mere "possibility" of irreparable harm, and instead suggest that such harm is "likely," *Winters*, 129 S. Ct. at 375-76. And the unfavorable resolution of Peter's administrative appeal, which the defendant emphasizes

as reason to deny an injunction here [see Doc. 70], is actually additional evidence of the likelihood that the plaintiffs' rights in necessary services will not be protected and that they will be forced into institutional facilities but for Court action, now.

For all these reasons, the plaintiffs have established a likelihood of irreperable harm.

Balance of Harms

In contrast to the irreparability of the harm facing the plaintiffs, the harm to the defendants if an injunction is granted is at most slight. With an injunction, the defendants will only have to maintain the same level of funding they have provided to the plaintiffs for years and which, in the instances, of Michelle M. and Chip E., they maintain even now. Further, and as already detailed, the record indicates that maintaining the plaintiffs' current level of community based services actually presents an overall cost *savings* per year to alternative placements. To all of this, the defendants have made little rejoinder. They have not attempted to explain how the injunction would peculiarly burden them in any respect, much less to some degree more than the consequences posed to the plaintiffs in the absence of the same. The relief requested is temporary in nature; commensurate with what the defendants have largely been providing the plaintiffs even subsequent to the amendments; and demands no sort of systemic alteration. The request is for the *status quo* not some new buffet of benefit or other "fundamental alteration."

In all of its consideration, the Court does not mean to suggest that the call has been an obvious one. The defendants' objections largely sound in reasonableness and legal basis. Both the timeliness of this lawsuit and the urgency of the harm alleged, are matters

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

Public Interest

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

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

CONCLUSION

Wherefore, it is RECOMMENDED that the plaintiffs' Motion for Injunctive Relief [Doc. 12] be GRANTED and the defendants be ordered to maintain and/or return services in the quality, kind, and volume enjoyed by the plaintiffs prior to January 1, 2010, and, in the case of Peter B., prior to July 2009.

IT IS SO RECOMMENDED.

s/Bruce Howe Hendricks
United States Magistrate Judge

November 24, 2010
Greenville, South Carolina

K1,0000858078 IN ADM 12/19/11SE
MYERS,ALBERT C
MUNN,SUSAN B MD
MRN M000181236 AGE 34
DOB 12/04/1977 RACE CA

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
PASARR Level I SCREENING

Name: Albert C. Myers	Date of Review: December 19, 2011
SSN: 248-39-8858	Location at assessment: KH Karesh LTC
Medicaid: 69222227D1 Non-Medicaid:	CLTC#:
Date of birth: December 4, 1977	Referral source: KH Karesh LTC

All Diagnosis (If dementia diagnosed or suspected, complete and attach the Mini-Mental Form):
Mental Retardation
Arthrogryposis, Unilateral Bilateral Cleft Lip Repaired Clubfeet,
Bilateral Hip Dislocation, Cerebral Palsy, Seizure Disorder

I. SCREENING FOR MENTAL RETARDATION INDICATORS

	YES	NO
1. Diagnosis of mental retardation or related disability made prior to age 22?	✓	
2. IQ tested below 70?	No	Data
3. Was time of test prior to age 22?	No	Data
4. Does client have 3rd grade education? If not, state reason in Comments Section.	✓	
5. Adaptive behavior: Could client ever perform self-care activities?		✓
- Did he/she help care for spouse/parents/children?		✓
- Was client ever able to cook and perform household duties?		✓
- Was client gainfully employed? If not, explain in Comments Section.		✓
- Did client have driver's license?		✓
6. Cognitive Functioning:		✓
- Memory: Does client remember what he/she had for breakfast or lunch?		✓
- Simple math: Can client add 12 + 8?		✓
- Concept formation: Can client describe the difference between a fish and dog?		✓

7. Comments: _____

II. SCREENING FOR MENTAL ILLNESS INDICATORS

1. Diagnosis of mental illness: ☒ No ☐ Yes Diagnosis: _____

2. History of psychiatric hospitalization within previous 2 years. (Give dates of treatment) ☐ No hospitalization

__/__/__ to __/__/__ __/__/__ to __/__/__ __/__/__ to __/__/__

3. Current behavioral indicators:
- ☐ Attempted suicide
- ☐ Assaultive
- ☐ Incessant loud talking
- ☐ Uncooperative
- ☐ Hostile
- ☐ Self-mutilation
- ☐ Combative
- ☐ Social isolation
- ☐ Destruction of property
- ☐ Unrealistic fear of strangers
- ☐ None of these indicators

4. Comments (Include explanation of major symptoms): _____

12-19-11 Marcia Jennings

2012-Jan-05 02:55 PM KERSHAW HEALTH - KARES848 803-713-6433

K1000085B078 KH ADM 12/19/1128X M
MYERS,ALBERT C
MUNN,SUSAN B MD
MRN M0000121234 AGE 34
DOB 12/04/1977 RACE CA

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
PASARR Level I SCREENING

NAME: Albert C. Myers SSN: 248-39-8838

III. LIST ALL PSYCHOTROPHIC DRUGS PRESCRIBED INCLUDING DOSAGE AND FREQUENCY.

1. Clonazepam 0.125 mg crushed and dissolved
2. via G-tube TID
3. Clonazepam 0.5 mg one crushed and dissolved via G-tube q hs
4.
5.
6.

IV. RECOMMENDATION OF REVIEWER:

- [x] Recommend further evaluation based on mental retardation indicators.
- [ ] Recommend further evaluation based on mental illness indicators.
- [ ] No further evaluation recommended.
- [ ] No further evaluation recommended, but indicators present. (State reasons below.)

Comments: (Give justification for above recommendations, if needed.)
Resident has a diagnosis of Mental Retardation. Level II PASARR attached

V. PERTINENT INFORMATION

- [ ] IMD admission requested; if so, indicate facility:
- [ ] Primary diagnosis of dementia; must be confirmed by a Mini-Mental Form.

Information obtained from: Resident's medical record CLTC Area # 7
Signature and title of assessor: Marcia Turner, LBSW Date: 12-19-11
Agency/institution completing form: KH Karesh LTC
Admitting Nursing Facility: KH Karesh LTC Date of Admission (if known) 12-19-11

FOR CLTC/IOC USE ONLY Reviewed by Nurse Consultant: _____ (initials)
Date Reviewed: _____

VI. ADVANCE CATEGORICAL DETERMINATION

- [ ] Advance categorical determination that specialized services are not required:

- [ ] 1. Severity of physical impairments overrides need for specialized services (MI only)
- [ ] 2. Nursing facility respite not to exceed 14 days (MR or MI)
- [ ] 3. Emergency admission due to suspected abuse/neglect under authority of DSS (MR or MI)
- [ ] 4. 30-Day time limited certification (MR or MI)
- [ ] 5. Mental retardation with concurrent diagnosis of dementia (MR only)

Signature of CLTC Nurse Consultant: _____

Date sent to nursing facility: _____ Initials: _____

Original Date: 05/01/11 KH Item # 17012 2 of 2 DHHS Form 234 (1/96) Previous Editions are Obsolete.

12-19-11 Marcia Turner LBSW

4/31

2012-Jan-05 02:55 PM KERSHAW HEALTH - KARES5698 803-713-6433 3/5

LEVEL II SOUTH CAROLINA MENTAL RETARDATION AUTHORITY DETERMINATION

Resident Name: Albert Myers Resident Location: Community

Medicaid #: 6922212701 Social Security #: 248-39-8858

The South Carolina Department of Disabilities and Special Needs (SCDDSN), the mental retardation authority in South Carolina, has conducted a review and interpretation of all data stipulated in Pre-admission Screening and Resident Review regulations relative to the named individual seeking placement or continued stay in a nursing facility. This is not a determination of whether the person needs nursing home placement.

Regional Name: Community Long Term Care – Area 7

1. The individual does [X] does not [ ] have mental retardation as defined under current PASARR regulations.

2. The individual requires:

[X] Services of lesser intensity to be provided or arranged for by the nursing facility as described below. Examples include: Structured socialization activities, drug therapy and monitoring of drug therapy, crisis intervention services, development and training of necessary daily living skills and development of personal support networks.

Based upon the available data (and to the extent possible), the South Carolina Department of Disabilities and Special Needs has identified the following specific services that may be required to meet the individual's needs.

See notes

[ ] Specialized services (active treatment) which are very intensive services and must be provided or arranged for by the South Carolina Department of Disabilities and Special Needs.

Based upon the available data (and to the extent possible), the South Carolina Department of Disabilities and Special Needs has identified the following specific habilitation services that may be required to meet the individual's needs.

DIAGNOSIS: Cerebral Palsy; Seizure Disorder; Scoliosis; Club feet; Arthrogrypothies

Basis for conclusions: Albert Myers is a 34 year old nonverbal male who has been receiving DDSN services under the Related Disability category since Oct. 1988. He presently requires total assistance from others in meeting the demands of all activities of daily living. Likewise, he requires comprehensive medical care and sound medication monitoring. He does not present with any significant behavioral concerns.

Brian K. Hawkins, MA

12/13/11
Date

K10000858078 IN ADM 12/19/11SEX M
MYERS, ALBERT C
MUNN, SUSAN D MD
MRN M0001912J4 AGE 34
DOB 12/04/1977 RACE GA

2012-Jan-05 02:55 PM KERSHAW HEALTH - KARESI8033713-6433 4/8

DHHS MEDICAID ELIGIBILITY APPROVAL AUTHORITY

12-13-11
DATE

K10000858078 IN APM 12/19/11SEX M
MYERS,ALBERT C
MUNN,SUSAN B MD
MRN MG00181236 AGE 34
DOB 12/04/1977 RACE CA

2012-Jan-05 02:55 PM KERSHAW HEALTH - KARESH5803-713-6433

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

NOTICE OF TERMINATION OF SERVICE

To: Kershaw County DSNB

Address: P.O. Box 310
Camden South Carolina 29021

Participant's Name: Albert Myers DOB: 12/04/1977 Medicaid #: 6922222701

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE(S) TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF 01/10/2010 MAY BE BILLED.

- ☐ Adult Attendant Care Services
- ☐ Adult Day Health Care
- ☐ Adult Day Health Care Nursing
- ☐ Adult Day Health Care Transportation
- ☐ Adult Companion Services
- ☐ Adult Dental Services
- ☐ Adult Vision Services
- ☐ Audiology Services
- ☐ Behavior Support Services
- ☐ Career Preparation Services
- ☐ Community Services
- ☐ Day Activity
- ☐ Employment Services
- ☐ Environmental Modifications
- ☐ Nursing Services
- ☐ Personal Care Services
- ☐ Personal Emergency Response System (PERS)
- ☐ Prescribed Drugs
- ☐ Private Vehicle Modifications
- ☐ Psychological Services
- ☐ Residential Habilitation
- ☒ Respite Care Daily Respite
- ☐ Specialized Medical Equipment, Supplies and Assistive Technology
- ☐ Speech-Language Pathology
- ☐ Support Center Services

Reason:

- ☐ Change in need; no longer justifies original request
- ☐ No longer meets ICF/MR Level of Care
- ☐ Change in provider availability
- ☐ Entered an ICF/MR
- ☐ Voluntary withdrawal
- ☐ Death (do not send a copy to the family)
- ☐ Medical condition has improved
- ☐ Participant/legal guardian requested
- ☐ Medicaid ineligible
- ☐ Participant moved out of state
- ☐ Facility stay exceeded 30 consecutive days
- ☒ Other (explain in comments below)

Comments (required): Daily Respite is no longer covered under the MR/RD waiver.

Service Coordination Provider: Kershaw County DSNB Service Coordinator Name: Brandy Carolina

Address: P.O. Box 310
Camden South Carolina 29021

Phone # (803) 432-4841

Signature of Service Coordinator

12-31-2009
Date

Original: Provider / Copy: Participant/legal guardian, File

APPEALS PROCESS MUST BE ATTACHED

MR/RD Form 16-B (Revised 12/09)

S.C. DEPA.. MENT OF DISABILITIES AND S. .CIAL NEEDS
MR/RD WAIVER

NOTICE OF REDUCTION OF SERVICE

To: Care Pro Medical One

Address: P.O. Box 1786
Columbia South Carolina 29202

Participant's Name: Albert Myers DOB: 12/04/1977 Medicaid #: 6922222701

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE(S) TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF 01/09/2010 MAY BE BILLED.

- ☐ Adult Attendant Care Services
- ☐ Adult Day Health Care
- ☐ Adult Day Health Care Nursing
- ☐ Adult Day Health Care Transportation
- ☐ Adult Companion Services
- ☐ Adult Dental Services
- ☐ Adult Vision Services
- ☐ Audiology Services
- ☐ Behavior Support Services
- ☐ Career Preparation Services
- ☐ Community Services
- ☐ Day Activity
- ☐ Employment Services
- ☐ Environmental Modifications
- ☐ Nursing Services
- ☒ Personal Care Services
- ☐ Personal Emergency Response System (PERS)
- ☐ Prescribed Drugs
- ☐ Private Vehicle Modifications
- ☐ Psychological Services
- ☐ Residential Habilitation
- ~~☒ Respite Care~~ (68) effective 12/20/09
- ☐ Specialized Medical Equipment, Supplies and Assistive Technology
- ☐ Speech-Language Pathology
- ☐ Support Center Services

Reason:

- ☐ Change in need; no longer justifies original request
- ☐ No longer meets ICF/MR Level of Care
- ☒ Other: Decrease in services , cap in services by DDSN
- ☐ Medical condition has improved
- ☐ Participant/legal guardian requested

Comments (required): Respite Care has been cap to 68 hours per month, and personal care has been cap to 28 hours per week.

Service Coordination Provider: Kershaw County DSNB Service Coordinator Name: Brandy Carolina

Address: P.O Box 310
Camden SC 29021

Phone # (803)432-4841

Signature of Service Coordinator

12-20-2009
Date

Original: Provider / Copy: Participant/legal guardian, File

APPEALS PROCESS MUST BE ATTACHED

MR/RD Form 16-D (Revised 12/09)

8/31

853

SOUTH CAROLIN[A] DEPARTMENT OF DISAB[ILI]TIES AND SPECIAL NEEDS
MR/RD WAIVER-NOTICE OF TERMINATION OF SERVICE

DATE FORM IS COMPLETED: December 30, 2009

PROVIDER: Camden Rehab

301-B East DeKalb Street Camden SC 29020

RE: Albert Cocter Myers (Recipient's Name) 12/4/1977 (Date of Birth)

Medicaid #: 0 9 2 2 2 2 2 7 0 1

YOU ARE HEREBY NOTIFIED TO TERMINATE THE PROVISION OF THE FOLLOWING SERVICE TO THE PERSON NAMED ABOVE. ONLY THE NUMBER OF UNITS RENDERED PRIOR TO OR ON THE EFFECTIVE DATE OF 01/09/2010 MAY BE BILLED.

For SC/EI: the effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, or admission to an ICF/MR or NF. This allows the consumer 10 days notice prior to termination of service.

- ☐ Respite Care
- ☐ Adult Day Health Care
- ☐ Assistive Technology:
- ☐ Personal Care Services
- ☐ Medicaid Waiver Nursing Services
- ☐ Habilitation (specify)
  - ☐ Residential habilitation
  - ☐ Day Habilitation
  - ☐ Prevocational services
  - ☐ Supported Employment services
- ☐ Prescribed Drugs
- ☐ Adult Dental Services
- ☐ Daily Respite
- ☐ Environmental Modifications
- ☐ Audiological Services
- ☐ Psychological Services
- ☐ Behavior Support Services
- ☑ Physical Therapy Services
- ☐ Occupational Therapy
- ☐ Speech-Language Services
- ☐ Adult Vision Services
- ☐ Adult Companion Services
- ☐ Private Vehicle Modifications

Reason:

- ☐ Change in need no longer justifies original request
- ☐ Change in/no longer meets ICF/MR Level of Care
- ☐ Change in provider availability
- ☐ Entered an ICF/MR
- ☐ Voluntary withdrawal
- ☐ Death (do not send a copy to the family)
- ☑ Other
- ☐ Medical condition has improved
- ☐ Consumer/legal guardian requested
- ☐ Medicaid ineligible
- ☐ Consumer moved out of state
- ☐ Hospital/Nursing home stay exceeded more than 30 consecutive calendar days

Comments (required for all reasons): Physical Therapy will no longer be covered under the MR/RD Waiver

Service Coordinator/Early Interventionist: Brandy D. Carolina

DSN Board/Provider: Kershaw County DSNB Phone: (803) 432-4841

Address: PO Box 310 Camden SC 29021

Signature: Brandy D. Carolina Date: 12/30/2009

Original: Provider Copy: Consumer/Legal Guardian and File

MR/RD Form 16-B (10/04) APPEALS PROCESS IS ATTACHED

Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director Operations
Kathi K. Lacy, Ph.D.
Associate State Director Policy

South Carolina Department of Disabilities and Special Needs

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
V/TTY- 803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

COMMISSION
Kelly Hanson Floyd
Chairman
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Otis D. Speight, MD, MBA, CPE
Secretary
W. Robert Harrell
Nancy L. Banov, M.Ed.
Susan K. Lait
Deborah C. McPherson

To: Service Coordinator Brandy Carolina
DSN Board / Qualified Provider Agency Kershaw

From: Dawn Shealy
District I

Date: January 15, 2010

The Respite Limit Exception has been received for Alberto Myers.

After reviewing the request and all supporting documentation the team has made the following decision (s):

___ Approval of _____ hours monthly.

✓ Modified to 101 hours monthly.

___ Denied

The WTS will be updated to reflect the approved amount.

If you have any questions please contact me at (864) 938 -3356 or dshealy@ddsn.sc.gov.

DISTRICT I

P.O. Box 239
Clinton, SC 29325-5328
Phone: 864/938-3497

Midlands Center - Phone: 803/935-7500
Whitten Center - Phone: 864/833-2733

DISTRICT II

9995 Miles Jamison Road
Summerville, SC 29485
Phone: 843/832-5576

Coastal Center - Phone: 843/873-5750
Pee Dee Center - Phone: 843/664-2600
Saleeby Center - Phone 843/332-4104

10/31

855

S.C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

NOTICE OF DENIAL OF SERVICE

To: Albert Myers (Please check one: ☒ Participant ☐ Legal Guardian)

Address: 106 Hunt Club Lane
Camden, SC 29020

Participant's Name: Albert Myers DOB: 12/4/1977 Medicaid #: 6922222701

YOU ARE HEREBY NOTIFIED THAT THE REQUEST FOR THE FOLLOWING SERVICE(S) FOR THE PERSON NAMED ABOVE HAS BEEN DENIED. EXPLANATION OF APPEAL RIGHTS IS ATTACHED.

- ☐ Adult Attendant Care Services
- ☐ Adult Day Health Care
- ☐ Adult Day Health Care Nursing
- ☐ Adult Day Health Care Transportation
- ☐ Adult Companion Services
- ☐ Adult Dental Services
- ☐ Adult Vision Services
- ☐ Audiology Services
- ☐ Behavior Support Services
- ☐ Career Preparation Services
- ☐ Community Services
- ☐ Day Activity
- ☐ Employment Services
- ☐ Environmental Modifications
- ☐ Nursing Services
- ☐ Personal Care Services
- ☐ Personal Emergency Response System (PERS)
- ☐ Prescribed Drugs
- ☐ Private Vehicle Modifications
- ☐ Psychological Services
- ☐ Residential Habilitation
- ☒ Respite Care
- ☐ Specialized Medical Equipment, Supplies and Assistive Technology (* listed below)
- ☐ Speech-Language Pathology
- ☐ Support Center Services

* Assistive Tech: ____

Reason:

- ☐ Need(s) not justified
- ☐ Service(s) available through State Plan Medicaid
- ☐ Exceeds service limits
- ☒ Other: Services are going through appeal

Comments (required): His appeal is not over, no more hours can be approved until appeal is over how ever he will continue receiving 101 units as he has been receiving

Service Coordination Provider: KCBDSN Service Coordinator Name: Juanita Auker

Address: PO BOX 310
CAMDEN, SC 29020

Phone # 803-432-4841 ext 106

Signature of Service Coordinator — Date: 7/29/11

Original: Participant/legal guardian / Copy: File

APPEALS PROCESS MUST BE ATTACHED

MR/RD Form 16-A (Revised 12/09)

11/31

856

Activity Date: 6/22/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Brandy Carolina, Service Coordinator on 6/24/2010

Activity Types: Monitoring **Contact Types:** No Contact

SC B Carolina annualized Albert MR/RD Waiver budget for the 2010-2011 year. SC increased uints for Day Activity, and Community Support to 520 per year for each service on the waiver budget. SC will continue to check the waiver budget for approval by SCS T Warren.

Activity Date: 7/20/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/28/2010

Activity Types: Non-Reportable Activity **Contact Types:** Other

LATE ENTRY

SC received and reviewed Albert's (c) file. SC thought she had written a note but had not. FU- will continue.

Activity Date: 7/26/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/28/2010

Activity Types: Non-Reportable Activity, Monitoring or Follow-Up **Contact Types:** Telephone

SC contacted Mrs. Myers, mother of Albert (c) to inform her that she is now Albert's SC. We discussed Albert's case a little and SC gave her information including phone number and email address to contact SC if needed. FU- will continue.

Activity Date: 7/29/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/29/2010

Activity Types: Monitoring or Follow-Up **Contact Types:** Other

SC received and reviewed respite time sheet for Albert (c) from Lisa, Respite caregiver. The total of hours was 49 for 6/16-6-29. SC approved time and forwarded to Lucy Bates in Finance for check processing. FU - will continue.

Activity Date: 8/10/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 8/11/2010

Activity Types: Monitoring or Follow-Up **Contact Types:** Office Visit

SC received and reviewed respite time sheets for Albert (c) from Lisa, Respite caregiver. The total of hours was 49 for 7/14-7/27 and 49 hours for 7/28-8/10 . SC approved time and forwarded to Lucy Bates in Finance for check processing. FU - will continue.

Activity Date: 8/19/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 8/23/2010

Activity Types: Monitoring or Follow-Up **Contact Types:** Office Visit

SC met with Brandy Carolina (Day Program Coordinator) to gather information for Albert's (c) quarterly review. SC inquired how he was doing in the day program. She stated that he was doing well. In the area of Day Activity he met his objective and will have a new objective. In the area of Community Support Services he started a new objective in July in the area of Self advocacy. FU- will continue.

Activity Date: 8/31/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 8/31/2010

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone

SC contacted Ms. Myers, mother of Albert (c) to complete Albert's quarterly review. SC inquired how Albert is doing at home. She stated that he is doing well. SC inquired if they are satisfied with all his services. She stated that they are satisfied with all services. SC inquired if he has had any dental or medical appointments. She stated that he has not had any dental appointments but did have a well check up this quarter with no problems reported. SC inquired if he has been to a OT or speech therapist. She stated no that she has not found one for either yet. SC stated that she would work with her to find one. She agreed. SC inquired if there are any new needs. She stated no. SC completed quarterly review. FU- will continue.

Activity Date: 9/22/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 9/24/2010

Activity Types: Monitoring or Follow-Up **Contact Types:** Letter

SC received and reviewed supervisory visit from Care Pro for PCA services for Albert (c). The date of the visit was 9/11/10. SC filed form. FU- will continue.

Activity Date: 11/24/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 11/28/2010

Activity Types: Monitoring or Follow-Up **Contact Types:** Face-to-Face

SC met with Albert (c) in the day program to gather information for his quarterly review. SC inquired how he was doing. He gave no response. SC inquired if he was doing ok. He moved his hand to yes on his chair table top.

SC inquired if he was satisfied with his services. He again moved his hand to yes. SC inquired if he had new needs or concerns. He moved his hand to no. SC gathered information for his quarterly review. FU- will continue.

Activity Date: 11/30/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 12/7/2010

Activity Types: Monitoring or Follow-Up **Contact Types:** Office Visit

SC met with Brandy, Day Program Coordinator to gather information for Albert's (c)quarterly review. SC

Inquired how he has been doing on his objectives. She stated that in August he regressed in his am objective and made slight progress in pm objective. In September he made progress in his am objective and slight regression in his pm objective. In October he had slight regression in am objective and regressed in his pm objective. SC contacted Ms. Myers to complete Albert's quarterly review. SC inquired if she is satisfied with all his services. She stated yes. SC inquired if there is any new needs. She stated no. SC completed his quarterly review. FU- wil continue.

Activity Date: 12/7/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 12/7/2010

Activity Types: Monitoring or Follow-Up
Non-Reportable Activity

Contact Types: No Contact

SC did not realize she did not complete all need forms for Albert (c) for his November quarterly. I had completed it but it only saved it because I did not put my number in to actually complete it on system, but information was in 11/30. SC completed monitorship on all needs on 11/30.

Activity Date: 12/15/2010 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 12/16/2010

Activity Types: Monitoring or Follow-Up
Non-Reportable Activity

Contact Types: Letter

SC received and reviewed a supervisory note from Care Pro for Albert (c), no problems reported. SC filed in chart. FU- will continue.

Activity Date: 2/4/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 2/4/2011

Activity Types: Assessment

Contact Types: Other

SC has reviewed documentation regarding Albert (c) to determine if per Medicaid guidelines if he meets Level of Care (LOC). SC has determined upon reviewing documentation that Albert continues to meet LOC requirements according to Medicaid Criteria. He continues to receive long term care at the Intermediate Level for the Mental Retarded. All MR/RD Waiver services should continue. SC completed form on CDSS. SC filed a copy in chart. FU will continue.

Activity Date: 2/8/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 2/8/2011

Activity Types: Monitoring or Follow-Up

Contact Types: Face-to-Face

SC met with Albert (c) in the day program to gather information for his quarterly review. SC inquired how he was doing. I asked if he was doing good. He looked towards the yes on his tray. SC inquired if he was satisfied with his services. He moved his hand to yes. SC inquired if he had new needs or concerns. He moved his hand to no. SC gathered information for his quarterly review. FU- will continue.

Activity Date: 2/8/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 2/10/2011 REVISED NOTE

Activity Types: Monitoring or Follow-Up

Contact Types: Telephone

SC contacted Ms. Myers, mother of Albert (c) to complete Albert's quarterly review. SC inquired how Albert is doing at home. She stated that he is doing well. SC inquired if they are satisfied with all his services. She stated that they are satisfied with all services. SC inquired if he has had any dental or medical appointments. She stated that he has not had any dental appointments or medical appointments. SC inquired if he has been to a OT or speech therapist. She stated no that she has not found one for either yet. SC stated no. SC inquired if there are any new needs. She stated no. SC gathered information for his quarterly review. FU- will continue.

Activity Date: 2/24/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 2/24/2011
REVISED NOTE
Activity Types: Monitoring or Follow-Up **Contact Types:** No Contact

SC completed the paperwork for respite for Albert (c) for January. He had a total of 108.5 hours. His case is still under appeal process. SC reviewed and approved it to be sent to Central Office. FU- will continue.

Activity Date: 2/28/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 2/28/2011
Activity Types: Monitoring or Follow-Up **Contact Types:** Office Visit

SC met with Brandy, Day program Coordinator to complete Albert's (c) quarterly review. SC inquired how he was doing on his objectives. SC reviewed his objectives. In Noveember he made slight progression in am objective and slight regression in pm. In December he regressed in am and slight regession in pm. In January his objective was revised in am and progressed in pm. SC completed his quarterly review. FU- will continue.

Activity Date: 3/9/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 3/9/2011
Activity Types: Monitoring or Follow-Up **Contact Types:** Office Visit

Lisa, Respite Caregiver met with SC to give her the respite sheet for Albert (c) for 2/23-3/8 for a total of 49 hours. SC approves respite and forwards to Lucy, Finance for check processing. FU- will continue.

Activity Date: 4/11/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 4/25/2011
Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone
LATE ENTRY

SC received a call from Ms. Myers, mother of Albert (c) stating that Lisa, the respite caregiver had gotten hurt while working. She stated that she needed help to take care of Albert. SC and Lead Service Coordinator Mrs. Thompson asked day program Coordinator Brandy Carolina and Day Program Supervisor Shontenna Jett if they had anyone that could go help with Albert. They did not have anyone. SC contacted Care Pro who covers the PCA II hours to see if they had a respite caregiver that could go as soon as possible. They were not able to find anyone but was able to go at the time for PCA II hours started with a new person because Lisa also did the PCA II hours for Albert. We discussed morning hours of PCAII. SC contact Care Pro to discuss those hours. Rosa stated that they would do their best to find someone. SC also discussed contacting friends and family to help while we got caregivers in place during this time. FU- will continue.

Activity Date: 4/12/2011 Contact Location: CDSS Setting Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 4/25/2011

Activity Types: Monitoring or Follow-Up Contact Types: Telephone
Other

LATE ENTRY

SC contacted Ms. Myers, mother of Albert (c) to see how things were going. She stated that Care Pro could not find another PCA to come this morning but had someone coming later to help her. SC stated we at KCBDSN did not have another respite person. SC stated that we could go through an agency. She stated that was fine she just needed help. SC inquired what provider. She stated it did not matter. SC stated she could try with Care Pro since they have found a PCA person. She stated that was fine. SC contaced Care Pro to inquire about respite and they did not have anyone. SC contacted Personal Care Plus and inquired about Respite services for Albert. They stated that they did believe that they had someone but would call SC back. They called SC back and stated that yes they had someone and she could start tomorrow. They stated they would call Mrs. Myers. SC also contacted Ms. Myers and informed her that Personal CARE Plus could provide respite. She stated that was good. SC stated that they would call her. SC faxed Personal Care Plus an authorzation for respite for 105 hours a month. SC informed them of the hours Lisa(Respite Caregiver) worked. SC looked further in the file and noticed SC miscalulated the respite hours. SC reviewed a note that SC Carolina had wrote that stated that Albert was approved for 101 hours a month with the exception. SC miscalulated the hours some how. Lisa was not working 101 hours a month, she was working 98 hours a month. SC faxed another authorzation to Personal Care Plus for the correct 101 hours a month, which is also in Albert's budget for 101 hours a month not 105. FU- will continue.

Activity Date: 4/13/2011 Contact Location: CDSS Setting Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 4/25/2011

Activity Types: Monitoring or Follow-Up Contact Types: Telephone
Care Planning
Assessment

LATE ENTRY

SC contacted Ms. Myers, mother of Albert (c) to see how things were going. She stated that things were still rough. SC stated that hopefully with the respite starting back today that would help. We discussed his services. SC also discussed Albert's up coming plan. SC stated that she was going to this week to set that up with her and then we had the emergency situation. SC informed her that it was due by 5/6. SC inquired if her and Albert wanted a plan meeting. She stated yes but was not sure about when because of everything going on. SC stated that she understood and that we could meet at her house if that helped. SC stated that we had the following week and the next week til 5/6 to have a meeting. She stated that SC and Brandi Carolina, Day Program Coordinator could come to the house at 3:30 on 4/27 to meet with her and Albert. SC agreed. SC agreed. FU- will continue.

Activity Date: 4/21/2011 Contact Location: CDSS Setting Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 4/25/2011

Activity Types: Care Planning Contact Types: Telephone

Ms. Myers, mother of Albert (c) contacted SC to inquired about Albert's plan being extended. SC stated that we could not extend his plan past 5/6 because it would be out of compliance and MR/RD Wavier services could not continue with a dead plan. SC stated that we still have the following week to meet 5/2-5/6. SC also stated that SC could complete plan and we could meet when she could and review and make changes if needed. She stated no that we could meet 5/3 at 3:00 at her house with her and Albert. SC agreed. SC left Brandy Carolina (Day Program Coordinator) a message for the changed date. FU- will continue.

Activity Date: 4/25/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 4/27/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Office Visit

Mr. Warren, ED met with SC to inform her that Patricia Harrison had emailed him about Al's (c) plan and that we would be setting meeting up through her. SC made copies of his last three assessments and plans as his budgets for the past 3 years. The budgets are a little off in 2010 and 2011 due to not being able to go beyond the caps. Al has continued to receive PCA II at 180 units a week and his hourly respite actually inceased to 101 hours a month before he only received 38 hours a month. PCA I was added and he receives 24 units a week. Physical Therapy has continued as he was getting. SC will wait to hear on day and time for meeting. FU - will continue.

Activity Date: 4/26/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 4/27/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone

SC received a call from Patricia Harrison inquiring about meeting for Al's (c) meeting on 4/28 at 5:00. SC stated that she would contact Mr. Warren, ED to discuss. SC contacted Mr. Warren and informed him of Ms. Harrison calling. He stated that he would call and contact SC back. Mr. Warren met with SC at office and stated that meeting would be at 4:30 at Chesco in Pontiac. SC informed Brandy, Day Program Coordinator and Ruby Thompson, Lead Service Coordinator so they could attend the meeting. FU- will continue.

Activity Date: 4/28/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 4/29/2011

Activity Types: Assessment **Contact Types:** Office Visit
Face-to-Face

SC met with Brandy (c) to gather information for Albert's (c) Annual Assessment. SC also met with Albert to gather information for his Annual Assessment. SC attempted to contact Ms. Myers, mother of Albert to gather more information for his annual assessment but was unable to reach her, SC left a message. FU- will continue.

Activity Date: 4/28/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 6/5/2011

Activity Types: Assessment **Contact Types:** Other
Monitoring or Follow-Up
Care Planning

SC met with Ms. Myers (mother of Albert), Tripp Myers (brother of Albert) Patrica Harrison (Lawyer repersenting Albert and Ms.Myers), Sandra (Lawyer also helping in Albert's case), Ruby Thompson (Lead Service Coordinator), Brandy Carolina (Day Program Coordinator), and Shontenna Jett(Day Program Supervisor)to review his Annual Assessment to make changes as needed and to complete his Annual Plan meeting. Mrs. Myers stated that she did not want Albert to attend meeting due to everything that needed to be discussed. SC gave Ms. Harrison a copy of Albert's assessment for this year to review. SC started meeting off by passing around the signature page for everyone to sign. SC also had following forms to discuss and review with Ms. Myers: SC Choice, Service Agreement, and MR/RD Wavier Rights. Ms. Harrison took forms to review and made changes to the MR/RD Rights Form. SC had a copy of the MR/RD

Rights and gave Ms. Myers a copy for her files. SC also gave the information to Ms. Myers about Abuse and how to Report Abuse and gave a book and handout on Preparing for Disasters. We started reviewing Albert's needs. Albert's needs. Mrs. Myers wanted to hold on to the SC Choice form and think about Service Coordination services and other providers. There were several needs and things to be changed on the Assessment. SC will make needed changes. It was stated that Albert needs more PCA II hours and respite hours. It was also stated that he needs Nursing hours for him to be fed. Mrs. Myers had stated that he has had a skin break down since Lisa (Respite/PCA II Caregiver) has left. Mrs. Myers stated that the lift they have is old and they are not using it. She stated that Albert needs a new lift. He also needs the doorway widened in the bathroom and needs a shower chair. He needs a speech evaluation, OT evaluation, and Psychological evaluation. He also needs a hearing and vision evaluation. Albert's information was also reviewed for day program. SC will make changes to Assessment and forward a copy to Mrs. Myers and Mrs. Harrison. FU- will continue.

Activity Date: 5/3/2011 Contact Location: CDSS Setting Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 5/5/2011 REVISED NOTE

Activity Types: Monitoring or Follow-Up Assessment
Contact Types: Telephone, Face-to-Face, Fax

SC contacted Mrs. Myers, mother of Albert to gather more information for his Annual Assessment. SC gathered needed information. She also informed SC of calling yesterday 5/2 while SC was out. She stated that she talked to Lead SC, Mrs. Thompson who helped her. She stated that she had wanted the new agency Personal Care Plus to be terminated due to the respite person not showing up and because of the non professional way they acted towards her. Mrs. Thompson sent termination form to Personal Care Plus and mailed Mrs. Myers a copy. SC made changes to Albert's (c) Assessment. SC met with Albert and SC stated that she was sending a copy of his Assessment home with him. He gave no response but did look at SC. SC contacted Mrs. Myers to inform her SC was sending that home with Albert. She stated she would look it over and call SC tomorrow. SC agreed. She also stated that they really need a lift as soon as possible. SC stated that she would look into that and give her a call back. Mrs. Myers had stated that they needed a lift with track system. We discussed having a consultation or someone looking at the house to see what would work. Mrs. Myers also stated that she found an agency for Respite. She stated she wanted Nightingales to provide respite for Albert. SC contacted Rosa at Nightingales and stated that she would fax authorization. She agreed and stated that they had people to provide the respite. SC faxed authorization to Nightingales for 101 units of respite a month. SC also faxed Mrs. Harrison, attorney a copy. FU- will continue.

Activity Date: 5/4/2011 Contact Location: CDSS Setting Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 5/5/2011 REVISED NOTE

Activity Types: Monitoring or Follow-Up Assessment
Contact Types: Telephone

SC contacted Dan, with Sure hands Lift and transfer to inquire about meeting with Albert (c) and Mrs. Myers, mother of Albert. He stated that he would be in the area tomorrow 5/5. SC inquired if there was a fee to met with them. He stated no. SC stated that she would give Mrs. Myers his number and let them set up a time. He agreed. SC contacted Mrs. Myers to give her the number. She stated she would call SC back. She contacted SC back and informed her that she will be at her house tomorrow after 3 so he can meet with them both. She stated that Dan had actually been there before to meet about a lift system. She stated she was looking forward to him coming out to see if he could help. She also informed SC of changes

to the Assessment. SC inquired with those changes if the Assessment was ok to complete. She stated yes that she is satisfied with the Assessment with the changes she had just told me. SC will complete assessment. Mrs. Myers stated that SC could also send Nightingales an authorzation for PCA II services. She stated that the lady working for Care Pro was going to start working for Nightingales and she wants that ald to continue working with Albert. She stated that services could start 5/6. SC will forward authorzation. FU- will continue.

Activity Date: 5/9/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 5/9/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone
Face-to-Face

SC received a call from Dan, with Sure Hands lifts stating that he did met with Albert (c) and Mrs. Myers, mother of Albert and was ready to send SC the estimate. SC gave him the fax number. SC also met with Albert to give him a copy of his plan. FU- will continue.

Activity Date: 5/10/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 5/11/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone

SC attempted to contacted Dan, with Sure Hands Lifts to inquire if he had sent the quote for the lift for Albert (c). SC was unable to reach him and left him a message. FU- will continue.

Activity Date: 5/11/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 5/11/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Other

SC received a phone message from Dan with Sure Hands Lifts that he will fax the information for the lift for Albert (c) in the next couple of days. He stated he was trying to wait on a local provider to do the installation but had not heard back from them. SC received information from Jacob Chorey, MR/RD Wavier Program Coordinator on funding for some of Albert's services on his plan. SC will update his plan as needed. FU- will continue.

Activity Date: 5/12/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 5/12/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone

SC attempted to contact Mrs. Myers, mother of Albert (c) to follow back up on the lift for Albert and discuss his services. SC left her a message. FU- will continue.

Activity Date: 5/13/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 5/19/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone

Mrs. Myers, mother of Albert (c) contacted SC back to discuss lift for Albert. We discussed the lift more and process of puting in on his budget. SC also stated that we needed to discuss his services and her request for more hours, along with discussing his Support Plan. SC inquuired about making home visit to discuss things in detail. Mrs. Myers agreed and stated she would get back with a date and time. SC agreed. FU- will continue.

Activity Date: 5/16/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 5/16/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone

SC received and reviewed the quote from Dan with Sure hands Lift and care systems for lift for Albert (c). The total amount was $7543.62. SC added amount on Albert's budget. SC will wait for approval to send authorzation. FU- will continue.

Activity Date: 5/19/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 5/19/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone

SC received a message on voice mail this morning that Mrs. Myers, mother of Albert had called. SC returned her call today. Mrs. Myers stated that she was wondering about holidays and other days center is closed. She was wondering about Memorial Day. I stated that we may not be able to get request in and approved by then. SC stated that was why she wanted to sit down and discuss his services. She stated SC could come 5/23. We agreed on 2:00. FU- will continue.

Activity Date: 5/23/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 5/23/2011

Activity Types: Non-Reportable Activity **Contact Types:** Telephone

Mrs. Myers, mother of Albert (c) contacted SC to cancell the appointment for today at 2:00. She asked about meeting tomorrow at 3:00. SC agreed. She inquired about another copy of Albert's support plan. SC printed a copy and put it in Albert's back pack as Mrs. Myers requested. SC also attacted a note that SC would discuss the changes already made to the plan in more detail. FU- will continue.

Activity Date: 5/24/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 5/27/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Face-to-Face
Home Visit

SC met with Mrs. Myers, mother of Albert (c) and she had Mrs. Harrison (Attorney) on speaker phone to discuss Albert's support plan and gather information for Albert's Respite exception. Albert came in from Day Program and SC spoke to him. He smiled at SC. His respite worker took Albert to his room. We discussed the respite exception they wanted it marked under Caregiver hospitalized or receiving medical treatment AND need for constant hands on /direct care and supervision due to medically complex condition or

severe disability. Mrs. Myers stated that she has back problems, a sciatica nerve. It was stated that he needs a total of 339 hours of respite a month due to his and his mother's health issues. They are wanting someone to be at the home from 9:30 at night til 6:00 am incase Albert has needs at night or there is an emergency. Mrs. Myers also stated that at this point her plan is to call 911 if she needs help at night for an emergency situation that she has no one to help or no one to call. We discussed his support plan. We discussed that SC was informed that they could not request more PCA II hours because Albert is already receiving over the cap amount due to the appeal. We discussed all updates SC made to plan. It was stated that he would need 8 hours of nursing a day. Mrs. Harrison stated she would get medical information needed for that and for the respite exception packet. Mrs. Myers requested 1 case a month of underpads for Albert. We discussed psychological services and they discussed Lennie Mullis providing service, but Mrs. Myers stated she did not know anyone else. SC will mail her a list of providers. Mrs. Myers also requested 2 more bottles of peri-wash a month. SC will have to check on this before adding to budget. We discussed PCA I services. SC stated that she still has this service but it has not been used. SC stated that she could give her a list of providers. She stated that she wanted to go with Nightingales, the agency where the other services are. SC stated that she would call and send authorization. Mrs. Myers showed SC Albert's room and bathroom to show where the lift was going and to show SC the door way of bathroom. FU- will continue.

Activity Date: 5/26/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 5/27/2011

Activity Types: Referral and Linkage; Monitoring or Follow-Up

Contact Types: Telephone; Fax

SC contacted Rhonda at Nightingales to inquire if they could fill the hours for PCA 1 services, 24 units a week for Albert (c). She stated yes. SC faxed an authorization for PCA I services to Nightingales. SC also contacted Dan, with Surehands lift to make sure his quote did not include the door widening along with lift system. He stated no that would be separate completed by a contractor. SC contacted Mrs. Myers, mother of Albert to inform her that the door widening would have to be under environmental modification and she would have to get three bids and that DDSN would go with the lowest bid. SC stated that she could send the Environmental modification fact sheet home with Albert. She agreed. She also inquired about people we have used for this service SC stated that she could give her a few names but that she could choose any licensed contractor to do the bids. SC put information in Albert's back pack and filed a copy. FU- will continue.

Activity Date: 5/27/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 5/27/2011

Activity Types: Referral and Linkage; Monitoring or Follow-Up

Contact Types: Telephone; Fax

SC faxed Donna Johnson at DDSN the quote for Albert's © lift with Sure Hands lift for his budget to be approved. Albert's budget was approved for the lift. SC contacted Mrs. Myers, mother of Albert to inform her of the approval. SC also stated that she put a copy of approved psychological providers in Albert's back pack. SC stated that if Lennie Mullis was still who she wanted to call SC back with who she chooses. SC faxed Dan with Sure Hands Lifts an authorization for the lift. FU- will continue.

Activity Date: 6/2/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 6/3/2011

Activity Types: Non-Reportable Activity **Contact Types:** Telephone

SC contacted Dan with Sure Hands Lift to inquire about where he was on getting the lift installed for Albert (c). He stated that he would pick up the equipment tomorrow and it would be installed over the weekend or early next week. SC will follow back up next week.

Activity Date: 6/9/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 6/14/2011

Activity Types: Non-Reportable Activity **Contact Types:** Telephone

SC contacted Mrs. Myers, mother of Albert (c) to inquire about the lift that was installed. Mrs. Myers stated that it was installed this week and it is great so far. She stated that she is satisfied with the lift and feels that she can use it to lift Albert if needed. SC also inquired about a psychological provider, if she had time to look list over. She stated she did and she wanted Lennie Mullis to provide the service for Albert. SC inquired if there are any new needs or concerns. She stated no. SC contacted Lennie Mullis to inquire if she could complete a psychological evaluation for Albert. She stated yes. SC inquired how many units were needed. She stated 8 units. SC will add units to budget and wait for approval to send authorzation. FU- will continue.

Activity Date: 6/14/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 6/14/2011

Activity Types: Non-Reportable Activity **Contact Types:** Telephone

Mrs. Myers, mother of Albert (c) contacted SC to inquire about getting an adult medium diaper for Albert instead of an adult small. SC stated she could send a new authorzation. SC also will add the underpads to the authorzation at Mrs. Myers request of needing a case a month. She wanted supplies to continue coming from Aftercare. She also stated that she is satisfied with the lift that was installed but may need to change out a sling so she has two of the same slings. SC inquired about coming to home to see lift and monitor PCA II services. We discussed days and times. We agreed on Thursday 6/16 at 6:45 pm. We also discussed Albert coming back to Day program but not being in Community Services. She agreed for him to be in Day Activity all day. SC terminated Community services, added more units to his budget for Day Activity for the service to be all day and not half day. SC completed authorzation for 6/15. SC gave Shontenna, Day Program Supervisor a copy of termination and new authorzation. Sc mailed Albert and Mrs. Myers a copy of termination. SC updated plan to show changes. FU- will continue.

Activity Date: 6/15/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 6/22/2011

Activity Types: Non-Reportable Activity **Contact Types:** Fax

SC received and reviewed a fax from Nightinglales for Albert (c) for the 30 day supervisory visit for PCA II services. SC filed in chart. Fu- will continue.

Activity Date: 6/16/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 6/20/2011 REVISED NOTE

Activity Types: Monitoring or Follow-Up **Contact Types:** Home Visit
Face-to-Face

SC met with Albert (c), Mrs. Myers (mother of Albert), and Lisa Jones (PCA) to monitor PCA II services and to monitor the Surehands lift. SC observed the PCA moving Albert from his wheelchair to the bed using the lift. Mrs. Myers stated that she is very satisfied with the lift in the bedroom but that there is some diffculty with using the lift in the bathroom. We went through the process. You have to lower the lift to pick it up, then there is diffculty lifting up to remove motor from hook and then you carry it to the bathroom and have to attach the motor to the hook in the bathroom. When you are done in the bathroom you have to go back through the process to get motor back in the bedroom. SC can see the diffculty in the process and agrees with needing another motor for the bathroom. SC also monitored Lisa getting Albert's things ready for the next day. SC inquired if he is satisfied with his PCA II service and caregiver. He smiled. SC discussed services futher with Mrs. Myers. SC inquired if she is satisfied with the provider. She stated yes so far. SC inquired if she is satisfied with the PCA's. She stated that Lisa is one of the first aids and she has worked out great. She stated that she has had some problems with aids but for the most part it is going well. SC inquired if there are any concerns or issues. She stated no. She stated that over the weekend she did have a problem with an aid but did report it to Nightingales. SC also inquired about the information needed for SC to request more respite hours. SC stated that Mrs. Harrison, Lawyer repersenting Albert was susppose to get SC information at the end of May but SC has not received information. She stated that the doctor had been on vaction and it held up the process. SC stated that when she received information she could sent it in to request more respite hours. She stated that she would check on it next week. SC also inquired about OT, Speech, and hearing evaluations. She stated that she would follow up on that next week too. SC monitored the lift and PCA II services. FU- will continue.

Activity Date: 6/20/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 6/20/2011

Activity Types: Non-Reportable Activity **Contact Types:** Telephone

SC contacted Dan, with Surehands Lift to discuss Mrs. Myers, mother of Albert (c) not being satisfied with the lift all the way. SC explained situation to him and we discussed further. He stated that he would get a quote to SC for another motor. FU- will continue.

Activity Date: 6/21/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011 **REVISED NOTE**

Activity Types: Non-Reportable Activity **Contact Types:** Fax

LATE ENTRY

SC thought she had completed this noted but after reviewing file had not. SC received and reviewed the quote from Dan, with Sure Hands Lifts for the other motor for Albert to use lift in his bathroom. SC added amount to his budget. The amount for motor is $4185.21. SC will fax authorzation to Dan once amount is approved. FU- will continue.

Activity Date: 6/23/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Non-Reportable Activity **Contact Types:** Other

LATE ENTRY

SC reviewed Albert's (c) budget and he was approved for 8 units for psychological evaluation. SC mailed Lennie Mullis, provider of choice an authorzation for evaluation. FU- will continue.

Activity Date: 7/7/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Non-Reportable Activity **Contact Types:** Email

LATE ENTRY

SC received email from Patrica Harroson, Albert's (c) attorney for his appeal emailing SC the letter from Albert's doctor stating the addional services he needs. SC will continue gathering information for nursing services and according to the letter more PCA II services. FU- will continue.

Activity Date: 7/14/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Non-Reportable Activity **Contact Types:** Other

LATE ENTRY

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. He can and will remain at 180 units while going through appeal but no more units can be approved because he is already over the cap.SC completed the denial of service for additional PCA II hours but he will remain at his 180 units a week while going through appeal. SC contacted Mrs. Myers, mother of Albert to inform her of this and sent home a copy of denial with appeal process with Albert in his book bag. SC also faxed Patrica Harrison a copy. FU- will continue.

Activity Date: 7/14/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Non-Reportable Activity **Contact Types:** Fax

LATE ENTRY

SC received and reviewed Albert's (c) psysican's order for nursing services from Dr. Munn at Camden Family Care. SC will continue gathering information for nursing services. FU- will continue.

Activity Date: 7/14/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Non-Reportable Activity **Contact Types:** Fax

LATE ENTRY

SC checked Albert's (c) budget and the motor was approved for the lift. SC faxed Dan, with Sure Hands the authorzation for the motor. FU- will continue.

Activity Date: 7/21/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Monitoring or Follow-Up, Referral and Linkage **Contact Types:** Other, Telephone

LATE ENTRY

SC had contacted Kay, in medical records at Camden Family Care to inquire on what was taking so long on getting Albert's (c) medical records. SC explained that she needed information to update his file and to request nursing services for him. She stated that request had not made it to her. She asked SC to fax authorzatuion to Release/obtain information and she was fax SC information. SC faxed her authorzation. She faxed over medical information for Albert for last three months. SC reviewed information. SC made a copy for package for requesting Nursing services and file other in file. SC completed information for Nursing services and faxed information to Vivian Koon at DDSN for review. FU- will continue.

Activity Date: 7/22/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone

SC contacted Lennie Mullis, Psychologial/counseling provider to inquire the staus of Albert's (c) psycjological evaluation. She stated that she met with Albert on 7/12 and she is finishing up the assessment and will mail it out to SC. She stated that she was recommending counseling due to his depression related to losing his caregiver Lisa (who has broke her hip) who provided respite and PCA II services and had been with him a very long time. She also stated he is having grief due to losing his father and grandmother. FU- will continue.

Activity Date: 7/26/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Other

SC received and reviewed Albert's (c) psychological assessment from Lennie Mullis, Psychogical provider, SC added 4 units a month for 12 months to his budget. SC will mail authorzation when approved. FU- will continue.

Activity Date: 7/28/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 7/28/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Other

SC received and reviewed an invoice and time sheets for respite for Albert from Nightgales for $794.80. SC approved invoice and forwarded to Cathy Williams. FU- will continue.

Activity Date: 7/28/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Referral and Linkage **Contact Types:** Other

SC checked Albert's (c) budget to see if the psychological services had been approved. His budget was approved and SC mailed Authorzation to Lennie Mullis, provider of choice. FU- will continue.

Activity Date: 7/28/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board
Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Non-Reportable Activity **Contact Types:** Other
Email

SC had completed information for Respite exception for Albert and had it ready to mail. 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. SC will inform Mrs. Myers, mother of Albert. FU- will continue.

Activity Date: 7/29/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Non-Reportable Activity **Contact Types:** Telephone

SC contacted Dan, with Sure Hands Lifts to inquire about Albert's (c) motor for the lift for bathroom. He stated that it was delivered last week. SC will contact Mrs. Myers, mother of Albert to see other motor. FU- will continue.

Activity Date: 7/29/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 7/29/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone

SC received a call from Mrs. Myers, mother of Albert (c) stating that Shontenna (Day Program Supervisor) had called about Albert's diapers being to big. We discussed the issue. She stated she would talk with Cassie at Aftercare and then if they could find something that worked she would coose another provider. She also inquired about more respite hours to cover days when center is closed and when Albert is sick. SC informed her that no more hours could be approved due to Albert going through appeal. SC suggested rearranging his hours when there is a holiday or he is sick. SC also informed her that she sent information in for Nursing and is waiting for approval. FU- will continue.

Activity Date: 8/10/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 8/15/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Home Visit

SC met with Albert (c) and Mrs. Myers, mother of Albert to monitor other part of lift and complete bi monthly contact. SC went to bathroom and watched Mrs. Myers and PCA II aid show how the lift lowered Albert into the bathtub. The lift worked and lowered him in the bathroom. The lift for bedroom and bathroom work appropriate and they are satisfied with them. However Mrs. Myers stated that she has been looking for some kind of device that would help her and the aid to give him a bath because leaving him in the sling in not working out. She has talked with Bill Hayes at All Medical and been looking around. She stated she would continue to look around and asked if SC could continue to look around. SC agreed. SC go fourth with paying for lift now seeing both parts. Mrs. Myers stated that she had guardianship completed yesterday 8/9 so she is now Albert's guardian. SC inquired if she is satisfied with all his services. She stated yes. SC inquired about Nightgales as a provider. She stated that she has been very satisfied with Nightingales and how they send people that are trained. She stated that Mrs. Munn, Albert's doctor is referring him to USC Rehab evaluation. We discussed how the counseling session went for Albert's assessment. She stated that her and Albert was very satisfied with the session and with Lennie Mullis, provider. She stated that Mrs. Mullis was coming out to the house today. SC inquired if there are any new needs at this time. She stated no. SC completed monitorship of the surehands lift and bi monthly contact. FU- will continue.

Activity Date: 8/11/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 8/15/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Fax

SC received and reviewed invoice from SureHands Lift and Care System for Albert (c). SC had them send a combined invoice for total amount. The first amount was $7,543.62 and the second amount is $4,185.21 = $11,728.82. The amount is for 3 cents more. SC contacted Kristen who sent the invoice and discussed issue. She stated that SC could take the amount off but because they combinded the invoices thats how it printed but that they are fine with taking the 3 cents off. SC will forward to Cathy, finiance for check processing. FU- will continue.

Activity Date: 8/15/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 8/15/2011

Activity Types: Non-Reportable Activity **Contact Types:** Other

SC made a copy of the SureHands invoice for Albert's (c)lift. SC gave Cathy, finance the invoice to pay and will wait to get a copy of check to send information to Central Office for payment for Board. FU- will continue.

Activity Date: 8/18/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 8/18/2011

Activity Types: Non-Reportable Activity **Contact Types:** Fax
Other

SC faxed Vicki Coleman, Wavier Coordinator medical and other needed documentation to support Albert (c) needing Adult Day Health services. SC also mailed Mrs. Myers, mother of Albert a copy of the Adult Day Haelth Nursing service chapter in ID/RD Wavier manual showing that you can not reveive Adult Day Health Nursing and Nursing services in same day. FU- will continue.

Activity Date: 8/18/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 8/18/2011

Activity Types: Non-Reportable Activity **Contact Types:** Other

SC completed the need for a lift for Albert (c). SC had not completed need yet. SC has been out to the house twice to see both parts of lift one for bedroom and bathroom. SC has forwarded invoice for lifts and will complete DDSN paperwork when she receives a copy of check from Cathy, Finance. FU- will continue.

Activity Date: 8/19/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 8/23/2011

Activity Types: Referral and Linkage **Contact Types:** Fax
Telephone
Other

SC checked Albert's (c) budget to see if Adult Day Health, Adult Day Health Nursing, and Adult Day Health transportation was approved. All services were approved. SC contacted Mrs. Myers, mother of Albert and Mrs. Carlton at Kershaw County Adult Day Center, provider of choice to inform them, that the budget was approved and service could start 8/22/11. Mrs. Myers was very satisfied that he was able to start so soon. SC also discussed terminating Day Activity on his plan due to him going to Kershaw County Adult Day Center. She stated yes that she wants that sservice terminated. SC completed the termination form for Day Activity and mailed a copy to Albert and Mrs. Myers and gave a copy to Shontenna, Day Program Director. SC completed authorzations for Adult Day Health, Adult Day Health Nursing, and Adult Day Health transportation. SC updated plan. FU- WILL CONTINUE.

Activity Date: 8/26/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 8/26/2011

Activity Types: Non-Reportable Activity. **Contact Types:** Other

Cathy Williams, Finance gave SC a copy of Vendor check for Albert's (c) lift. SC complete paperwork for DDSN for repayment to board for lift. SC mailed a copy of paperwork to Allorianna Hawkins at DDSN, finance. SC also forwarded a copy to Dawn, Finance here. SC filed a copy in chart. FU will continue.

Activity Date: 8/31/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 8/31/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Office Visit

SC met with Albert (c)and Mrs. Carlton, Director of the Kershaw County Adult Day Care. SC asked if Albert was doing good today. He looked toward the word yes on his communication board. SC inquired if he liked the adult center. He stated no. SC observed a while. Everyone was sitting watching a movie. Albert looked tired today. SC inquired how Albert was doing there. Mrs. Carlton stated that he is doing well, no problems to report. SC inquired if Albert was satisfied with his services Adult Day Health, Adult Day Nursing, and Adult Day Transportation. He looked towards the no on his communication board.SC will follow up with Mrs. Myers, mother of Albert to monitor the service further. SC completed on site monitorship. FU- will continue.

Activity Date: 9/2/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 9/7/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Letter

SC received and reviewed Albert's (c) counseling note from Mrs. Mullis, counselor provider of choice. The objectives are to decrease symptoms of depression,feelings of sadness as a result of death and loss of others; decrease feelings of sadness with regards to change, decrease feelings of sadness with reguards to transitions in life, and increase communication and social skills with others. Mrs. Mullis seen Albert on 8/9. She stated that he had several medical issues, including pink eye. She stated that he was in good spirts. Things discussed during meeting were communication devices, PCA'S, and placement situations. Service should continue as needed and approved. FU- will continue.

Activity Date: 9/15/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 9/16/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Office Visit

SC met with Mr. Warren, ED to review information for Albert's (c) Nursing request. We reviewed and discussed information. Based on the information provided by his medical doctor Nursing services are denied. The information does not show a need for Nursing services. Also, Albert receives Adult Day Health Care Nursing and can not receive that service and nursing services in the same day. SC will complete notice of denial of service and mail a copy. FU- will continue.

Activity Date: 9/16/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 9/16/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Letter, Fax

SC completed the Notice of denial of service for nursing services for Albert (c). SC mailed Albert and Mrs. Myers (mother of Albert a copy) and also faxed Mrs. Harrison, attorney a copy. FU- will continue.

Activity Date: 9/21/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 9/28/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Other

SC met with April, nurse at Kershaw County Adult Day Center to monitor his services (Adult Day Health, Adult Day Health Nursing, and Adult Day Health Transportation). SC inquired how Albert was doing there. She stated that he is doing well and no problems or concerns. SC observed Albert while there. He seemed content. No problems to report. FU- will continue.

Activity Date: 10/5/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 10/6/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Other

SC received and reviewed Albert's (c) counseling notes from Mrs. Mullis, Counselor. He was seen on 9/21 for 4 units of counseling. He seemed in good spirits. They continued to discuss the loss of caregiver Lisa and family events and schedule changes in home. Counseling objectives will continue as they are. FU- will continue.

Activity Date: 10/12/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 10/13/2011

Activity Types: Non-Reportable Activity **Contact Types:** Office Visit

Mr. Warren, ED met with SC to discuss Mrs. Myers, mother of Albert (c) having guradianship of Albert. We reviewed paperwork and he gave SC a copy to file in his chart. FU- will continue.

Activity Date: 11/28/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 12/5/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Telephone

SC contacted Mrs. Myers, mother of Albert (c) to complete his 6 month plan review. SC inquired how he has been doing. She stated that he is doing well. SC inquired if he had any doctor appointments recently. She stated that he went for bloodwork but no other appointments. She stated that she wanted to change to All Medical for his diapers, but wants to continue other supplies at AfterCare. SC will complete new authorzation for All Medical and Aftercare. We reviewed each of his plan needs in detail. She stated that she is satisfied with all services and providers. She stated that she needs to make him a dentist appointment soon. She stated that she is still working on finding an OT and a doctor to complete the

hearing test. She stated that she is also working on finding a provider for the communication device. SC inquired about enviomental modifcations for Albert's bathroom. She stated she still was not sure if she was going to go forward with that. She also stated that she may get some kind of cling for him because the showerchair they tried did not work and was unable to find one that Albert could use.SC inquired if there any new needs. She stated no that she is working with All Medical on some foot rests/straps for Albert's wheelchair. SC completed his 6 month plan review. FU- will continue.

Activity Date: 12/1/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 12/5/2011

Activity Types: Non-Reportable Activity **Contact Types:** Other

SC received and reviewed Albert's (c) counseling notes from Mrs. Mulls, counselor. The objectives are to decrease symptoms of depression,feelings of sadness as a result of death and loss of others, decrease feelings of sadness with regards to change, dcrease feelings of sadness with reguards to transitions in life, and icrease communication and social skills with others. Mrs. Mullis seen Albert on 11/2. She stated he had one medical appointment. His scollosis is at 70-90%, which means it has increased. She stated that he was in good spirts. Things discussed during meeting were communication devices, PCA'S, his new adult day health, and discussed loolng Lisa as a caregiver. No conerns noted or reported. Service should continue as needed and approved. SC filed in chart. FU- will continue.

Activity Date: 12/15/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 12/21/2011

Activity Types: Monitoring or Follow-Up **Contact Types:** Face-to-Face

SC met with Albert (c) at the Adult Day Center to see how he was doing and complete face to face contact. SC inquired if he was doing well. He smiled. They were all finishing up lunch and Albert was sitting waiting on everyone and what activity they were going to be doing. SC inquired if he liked attending the Adult Day Center. He smiled at SC. SC observed him for a few mintues and left. He seemed to be in good spirts and seemed content at the Day Center. SC completed face to face contact. While SC was there Mrs. Carlton stated that she was told that Albert's last day was either Friday or Monday. SC stated that she was unaware of that. SC contacted Mrs. Myers, mother of Albert to inquire about situation. She stated that yes Albert was going to the Karesh wing at KCMC on Monday afternoon. We discussed situation and SC discussed process of terminating serylces and Wavier. We also discussed that SC would still be involved just that his Wavier would be gone. Mrs. Myers agreed. SC will start process of terminating services as needed. FU- will continue.

Activity Date: 12/20/2011 **Contact Location:** CDSS Setting — Kershaw DSN Board

Electronically signed by Juanita Auker, Service Coordinator on 12/21/2011

Activity Types: Non-Reportable Activity **Contact Types:** Fax
Other
No Contact

SC completed termination forms for Albert (c) for all his sservices and faxed to each provider and mailed Lennie Mullis (counselor) her copy. SC mailed Mrs. Myers, mother of Albert a copy of all terminations along with appeal process. He entered in to Karesh Wing at KCMC on 12/19. FU- will continue.

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

November 9, 2009

Emma Forkner, Director
South Carolina Department of Health & Human Services
Department of Health & Human Services
1801 Main Street
Columbia, SC 29201

Dear Ms. Forkner:

I am pleased to inform you that your request to renew South Carolina's Home and Community-Based Waiver for Persons with Mental Retardation or Related Disabilities, as authorized under provisions of section 1915(c) of the Social Security Act, has been approved. This waiver renewal has been assigned control number 0237.R04, which should be used in future correspondence. The waiver renewal is effective January 1, 2010 through December 31, 2014.

Specifically, you submitted a renewal request on August 31, 2009 to continue to provide the following waiver services: Adult Day Health Care; Personal Care 1 & 2; Residential Habilitation; Respite; Extended State Plan Adult Dental; Adult Vision; Audiology Services; Extended State Plan Prescribed Drugs; Adult Attendant Care Nursing; Adult Companion Services; Adult Day Health Care Nursing; Adult Day Health Care Transportation; Behavior Support Services; Career Preparation Services; Community Services; Day Activity; Employment Services; Environmental Modifications; Nursing Services; Personal Emergency Response System (PERS); Private Vehicle Modifications; Psychological Services; Specialized Medical Equipment, Supplies & Assistive Technology and Support Center Services.

The following estimates of utilization and cost of waiver services have been approved:

	Unduplicated Recipients	Factor D	Total Waiver Costs
Year 1 (1/1/10 – 12/31/10)	6300	$51,869	$278,661,600
Year 2 (1/1/11 – 12/31/11)	6700	$52,350	$298,042,800
Year 3 (1/1/12 – 12/31/12)	7100	$53,607	$323,085,500
Year 4 (1/1/13 – 12/31/13)	7500	$56,320	$359,812,500
Year 5 (1/1/14 – 12/31/14)	7900	$59,078	$398,815,700

We appreciate the effort and cooperation provided by your staff during our review of this request. If you have any questions, please feel free to contact Kimberly Adkins-McCoy at (404) 562-7159.

Sincerely,

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

1007

H9

Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
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January 13, 2010

Ms. Carolyn C. Myers
106 Hunt Cup Lane
Camden, SC 29020

RE: Albert Myers

Dear Ms. Myers:

Thank you for your correspondence to outlining your concerns about changes to your son Albert's Mental Retardation/Related Disabilites (MR/RD) Waiver services.

As you may know, over the last year the South Carolina Department of Disabilites and Special Needs (DDSN) has suffered devastating state budget reductions. As a result of those reductions, limits or caps were placed on services in the MR/RD Waiver. Approval for these limits or caps was obtained from the Centers for Medicaid and Medicare Services (CMS). These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants.

While we understand and appreciate the hardship these changes may place on your family, we are not at liberty to exceed the established limits. Therefore, I must uphold the decision to reduce Personal Care II and Respite Services and eliminate Physical Therapy. We understand that you have requested that Albert's services remain in place while your reconsideration and appeal is being considered.

Thank you for the opportunity to respond to your concerns. We encourage you to continue to work with Albert's Service Coordinator to access services that will best meet his needs. If you wish to pursue this matter further, you have the right to request an appeal with the SC Department of Health and Human Services. The appeals process is attached for your information.

Sincerely,

Beverly A. H. Buscemi PhD

Beverly A.H. Buscemi, Ph.D.
State Director

Attachment

C: Brandy Caroline, Kershaw DSN Board
Vicki Coleman, District I
Kara Lewis, DHHS

DISTRICT I
P.O. Box 239
Clinton, SC 29325-5328
Phone: (864) 938-3497

Midlands Center - Phone: 803/935-7500
Whitten Center - Phone: 864/833-2733

9995 Miles Jamison Road
Summerville, SC 29485
Phone: 843/832-5576

DISTRICT II
Coastal Center - Phone: 843/873-5750
Pee Dee Center - Phone: 843/664-2600
Sleeby Center - Phone: 843/332-4104

CAROLYN COOPER MYERS
106 Hunt Cup Lane
Camden SC 29020
Phone (803) 432-0931
nettlesjr@bellsouth.net

February 11, 2010

Mr. Vastine Crouch,
Division of Appeals and Hearings
SC Dept. of Health and Human Services
PO Box 8206
Columbia, SC 29202-82-06

Dear Mr. Crouch,

I am requesting a fair hearing opposing the reduction and elimination of MR/DD Medicaid Waiver services for my son, Albert Cooper Myers. 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 his Physical Therapy., Occupational Therapy and Speech Therapy services and the denial of coverage for Augmented Communications evaluation and equiptment.

Attached is the denial of my request for reconcideration signed by Dr. Beverly Buskirni/SCDSN. Please advise me of the date and time for Albert's hearing. I am requesting that his fair hearing be held in his home town of Camden, SC.

Sincerely,

Carolyn C. Myers
for my son Albert C. Myers

APPEALS & HEARINGS
RECEIVED
FEB 16 2010
SCDHHS

Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

South Carolina Department of Disabilities and Special Needs

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
V/TTY: 803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

COMMISSION
Kelly Hanson Floyd
Chairman
Richard C. Huntress
Vice Chairman
Otis D. Speight, MD, MBA, CPE
Secretary
W. Robert Harrell
Nancy L. Banov, M.Ed.
Susan K. Lait
Deborah C. McPherson

To: Mr. Vastine G. Crouch, Director
SCDHHS Division of Appeals

From: Jacob Chorey, MR/RD Waiver Program Coordinator
SCDDSN Mental Retardation Division

Date: 18 February 2010

Re: Albert Myers

Prior to the renewal of the MR/RD Waiver on 1 January 2010, Albert Myers was authorized to receive the following amounts:

- 2 units per week of Physical Therapy
- 180 units (45 hours) per week of Personal Care 2
- 48 units (annually) of Daily Respite
- 456 units (annually) of Hourly Respite

When the waiver was renewed, it included service limits of 112 units (28 hours) per week of Personal Care 2 and 68 [hourly] units of Respite per month. Additionally, Daily Respite and Physical Therapy were eliminated from the waiver. These changes were approved by the Centers for Medicare and Medicaid Services (CMS). Mr. Myers' services were, consequently, reduced/terminated as follows to comply with the terms of the renewed waiver.

- Physical Therapy terminated
- 112 units (28 hours) per week of Personal Care 2
- Daily Respite terminated
- 68 [hourly] units of Respite per month – Mr. Myers has since been approved for an exception to the service limit for Respite. The exception grants him 33 additional units per month, for a total of 101.

DISTRICT I
P.O. Box 239
Clinton, SC 29325-5128
Phone: (864) 938-3497

Midlands Center - Phone: 803/935-7500
Whitten Center - Phone: 864/833-2733

DISTRICT II
9995 Miles Jamison Road
Summerville, SC 29485
Phone: 843/832-5576

Coastal Center - Phone: 843/873-5750
Pee Dee Center - Phone: 843/664-2600
Saleeby Center - Phone: 843/332-4104

Beverly A. H. Buscemi, Ph.D.
State Director
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South Carolina Department of Disabilities and Special Needs

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Nancy L. Banov, M.Ed.
Susan K. Lait
Deborah C. McPherron

To: Mr. Vastine G. Crouch, Director
SCDHHS Division of Appeals

From: Jacob Chorey, MR/RD Waiver Program Coordinator
SCDDSN Mental Retardation Division

Date: 24 February 2010

Re: Albert Myers

Prior to the renewal of the MR/RD Waiver on 1 January 2010, Albert Myers' complete, authorized service package through the waiver was as follows:

- Dental
- 5 units per week of Community Services
- 5 units per week of Day Activity
- Specialized Medical Equipment, Supplies and Assistive Technology – Peri wash, Attend Wash cloths, Diapers
- 4 units per week of Physical Therapy
- 180 units (45 hours) per week of Personal Care 2
- 48 units (annually) of Daily Respite
- 456 units (annually = 38 per month) of Hourly Respite

Please note that Mr. Myers was not receiving Speech-Language Pathology services prior to 1 January 2010.

When the waiver was renewed, it included service limits of 112 units (28 hours) per week of Personal Care 2 and 68 [hourly] units of Respite per month. Additionally, Daily Respite and Physical Therapy were eliminated from the waiver. These changes were approved by the Centers for Medicare and Medicaid Services (CMS). Mr. Myers' service package was, consequently, modified as follows to comply with the terms of the renewed waiver:

- Dental (unchanged)
- 5 units per week of Community Services (unchanged)

DISTRICT I
P.O. Box 239
Clinton, SC 29325-5328
Phone: (864) 938-3497

Midlands Center - Phone: 803/935-7500
Whitten Center - Phone: 864/833-2733

DISTRICT II
9995 Miles Jamison Road
Summerville, SC 29485
Phone: 843/832-5576

Coastal Center - Phone: 843/873-5750
Pee Dee Center - Phone: 843/664-2600
Saleeby Center - Phone: 843/332-4104

- 5 units per week of Day Activity (unchanged)
- Specialized Medical Equipment, Supplies and Assistive Technology – Peri wash, Attend Wash cloths, Diapers (unchanged)
- Physical Therapy terminated
- 112 units (28 hours) per week of Personal Care 2 (reduction)
- Daily Respite terminated
- 68 [hourly] units of Respite per month – Mr. Myers has since been approved for an exception to the service limit for Respite. The exception grants him 33 additional units per month, for a total of 101. (increase)
- 24 units (6 hours) per week of Personal Care 1 (addition)

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

TELEPHONE (803) 256-2017

FAX (803) 256-2213



March 15, 2010

Via Fax to 255 8206

Ms. Janet R. Goode
Office of Hearings and Appeals
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, South Carolina 29202-8206

RE: Appeal of Albert Cooper Meyers v. SCDHHS
Appeals Case #10-MISC-040 (MR/RD)

Dear Ms. Goode:

Please be advised that I represent Albert Cooper Meyers in this matter. Attached is the response to your Interlocutory Order. Please advise of the date and time of Al's hearing. We are requesting that this hearing be held in Kershaw County.

Thank you very much for your assistance.

Cordially,

Patricia L. Harrison

cc: Carolyn Meyers

South Carolina
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

March 16, 2010

Memorandum

To: Kara Lewis, CLTC Services, SCDHHS

From: Janet R. Goode, Hearing Officer
Division of Appeals, SCDHHS

Subject: 10-MISC-040

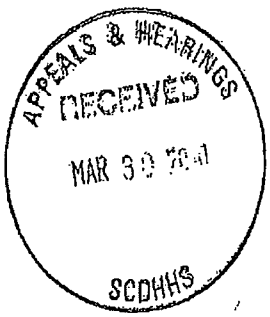
Enclosed is copy of documentation in file, Interlocutory Order dated February 25, 2010 and response to Interlocutory Order filed by Petitioner's representative with notification of attorney representation received March 15, 2010 for Respondent's review and opportunity for comment. If Respondent has comments, please respond to me in writing before March 30, 2010 and copy Ms. Harrison with your comments.

cc: Patricia L. Harrison
611 Holly Street
Columbia, SC 29205

South Carolina Department of Health & Human Services

Emma Forkner • Direc
Mark Sanford• Govern

March 30, 2010



Ms. Janet R. Goode, Hearing Officer
Division of Appeals and Hearings
South Carolina State Department of
Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Re: Meyers v. SCDHHS, 10-MISC-040 (MR/RD)

Dear Ms. Goode:

Enclosed for your consideration is the Departments' Return to Mr. Meyers' Reply to Interlocutory Order in this matter. Please take this letter as my notice of appearance in this matter and my certification that a true and correct copy of this Return has been sent to Ms. Patricia L. Harrison, Law Office of Patricia Harrison, 611 Holly Street, Columbia, SC 29205.

Please contact me if there are any questions. My direct is (803) 898-2791.

Sincerely,

Richard G. Hepfer
Deputy General Counsel

Enclosure

cc: Patricia L. Harrison, Attorney for the Petitioner

South Carolina Department of
Health & Human Services

Emma Forkner • Director
Mark Sanford • Governor

March 30, 2010

CERTIFIED MAIL

Patricia L. Harrison
611 Holly Street
Columbia, SC 29205

RE: Appeal Request in the Matter of Albert Cooper Myers v. SCDHHS
Appeals Case #10-MISC-040 (MR/RD)

Dear Ms. Harrison,

I am in receipt of Respondent's comments to your response dated March 15, 2010 to the Interlocutory Order dated February 25, 2010. Respondent's comments were received in Appeals and Hearings on March 30, 2010. I have enclosed a copy of the response in the event you have not received your copy from the Respondent. If you wish to comment further, please respond to me in writing by the close of business ten days from the date of your receipt of this correspondence. I will then make a determination, based on the evidence of record, whether a hearing is warranted or if the case is proper for dismissal.

Sincerely,

Janet R. Goode
Hearing Officer
Division of Hearings and Appeals

Enclosures

cc: Rick Hepfer, Deputy General Counsel, SCDHHS

South Carolina Department of Health & Human Services

Emma Forkner Director
Mark Sanford Governor

May 6, 2010

CERTIFIED MAIL

Patricia L. Harrison
611 Holly Street
Columbia South Carolina 29205

RE: Order of Dismissal in the Appeal Matter of Albert Cooper Myers v. SCDHHS
Appeals' Case # 10-MISC-040 (MR/RD Waiver)

Dear Ms. Harrison:

The Order of Dismissal in the referenced appeal matter is set forth in the enclosure.

Any party has the right to petition for further review of this Decision/Order, as provided in the Administrative Procedures Act [S.C. Code Ann. Section 1-23-310, et seq., (1976, as amended).] **To request an appeal, a Notice of Appeal must be filed with the Administrative Law Court, 1205 Pendleton Street, Brown Building – Suite 224, Columbia, S. C. 29201-3755 within thirty (30) days of receipt of this Decision/Order.** A copy of the Notice of Appeal should be provided to the S. C. Department of Health and Human Services' (SCDHHS) Office of General Counsel. The Notice of Appeal must be submitted in accordance with Rule 33 of the Rules of Procedure for the S.C. Administrative Law Court, which establishes specific requirements for the contents of a Notice of Appeal. Rule 35 directs that the party filing the Notice of Appeal is responsible for ordering the transcript and filing a copy of the request with the Notice of Appeal. The original request for transcript should be directed to the SCDHHS' Division of Appeals at the address below. **In accordance with the ALC rules, the cost of producing the transcript will be the responsibility of the party requesting appellate review.** For a copy of the ALC rules, you may contact the Administrative Law Court at (803) 734-0550.

Also, please see the enclosed Rule 71 of the Rules of Procedure for the ALC, which sets forth the required filing fee for an appeal.

Sincerely,

Vastine G. Crouch
Director, Division of Appeals and Hearings

VGC/sbs
Enclosures (2)

Division of Appeals and Hearings
Post Office Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2600 • Fax (803) 255-8206

From: Robert French
To: Byron Roberts; Patricia Harrison; 'Patricia L ...
Date: 11/16/11 11:26
Subject: Re: Recent SC ALC decision

Yes ma'am, thanks Ms. Harrison.

Robert French, Division Director
Division of Appeals and Hearings
SC Department of Health & Human Services
(803) 898-2714
(803) 255-8206 (Fax)
frenchr@scdhhs.gov

>>> "Patricia L Harrison" <plh.cola@att.net> 11/16/11 11:24 >>>
I have just returned from two out-of-town CLE's and also will need a day or two, but should be able to get a response to you by Friday, if that is satisfactory.

Trisha Harrison

-----Original Message-----
From: Robert French
Sent: Wednesday, November 16, 2011 10:32 AM
To: Patricia L Harrison ; Rick Hepfer ; Byron Roberts ; Patricia Harrison
Subject: Re: Recent SC ALC decision

Thank you, Mr. Hepfer.

Robert French, Division Director
Division of Appeals and Hearings
SC Department of Health & Human Services
(803) 898-2714
(803) 255-8206 (Fax)
frenchr@scdhhs.gov

>>> Rick Hepfer 11/16/11 10:29 >>>
Mr. French, I will need a day or two to confer with the agencies to determine our position on the Order. I know there is a deadline, and I will get an answer to you as soon as possible.

>>> Robert French 11/15/2011 9:44 AM >>>

Ms. Harrison and Mr. Hepfer,

I hope you can give me some help with regard to the November 9, 2011 Order from Judge Robinson. The Order does not remand the case to the Division of Appeals but reverses SCDHHS's decision and of course the Division of Appeals' decision. What confuses me is the sentence that reads, "IT IS FURTHER ORDERED that before taking any further action regarding Appellants' benefits under the MR/RD waiver, the Department must provide each Appellant with an evidentiary hearing consistent with the reasoning set forth above, within 60 days from the date of this Order."

I read this Order as directing the Division of Appeals to schedule a hearing within 60 days from November 9, 2011, in order to have these matters resolved at a hearing, do you agree?

I would appreciate your feedback on this issue.

Sincerely,

Robert French

Robert French, Division Director
Division of Appeals and Hearings
SC Department of Health & Human Services
(803) 898-2714
(803) 255-8206 (Fax)
frenchr@scdhhs.gov

Confidentiality Note
This message is intended for the use of the person or entity to which it is addressed and may contain information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED.

If you have received this in error, please notify us immediately and destroy the related message.

From: Robert French
To: Byron Roberts; Patricia Harrison; Patricia L ...
Date: 11/16/11 10:32
Subject: Re: Recent SC ALC decision

Thank you, Mr. Hepfer.

Robert French, Division Director
Division of Appeals and Hearings
SC Department of Health & Human Services
(803) 898-2714
(803) 255-8206 (Fax)
frenchr@scdhhs.gov

>>> Rick Hepfer 11/16/11 10:29 >>>
Mr. French, I will need a day or two to confer with the agencies to determine our position on the Order. I know there is a deadline, and I will get an answer to you as soon as possible.

>>> Robert French 11/15/2011 9:44 AM >>>

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I would appreciate your feedback on this issue.

Sincerely,

Robert French

Robert French, Division Director
Division of Appeals and Hearings
SC Department of Health & Human Services
(803) 898-2714
(803) 255-8206 (Fax)
frenchr@scdhhs.gov

From: Betsy Schindler
To: plh.cola@att.net; plh.cola@worldnet.att.net; Rick Hepfer
Date: 12/19/2011 11:32 AM
Subject: [secure] Appeal 11-MISC-302 Albert Myers

Good Morning Ms. Harrison & Mr. Hepfer,

I received your letters today about the appeals involved in Judge Robinson's Order of November 9, 2011 which directed hearings be held for these Medicaid beneficiaries within 60 days. As the assigned Hearing Officer for Albert Cooper Myers, I have scheduled his hearing to be held January 6, 2012 at 10:00 AM in the 9th floor conference room of the Jefferson Square building, 1801 Main St. Columbia. While I certainly understand Ms. Harrison's concern about having ample time to prepare for the hearing, the hearing will be held as scheduled.

If you choose to have a pre-hearing conference to clarify the issue, please send me an update of the results of the discussion. I will be in the office most of the next couple of weeks with the exceptions of the days the building is closed (12-23 to 12-27) and Dec. 30, if you have any questions for me. Happy Holidays

Betsy Schindler
Hearing Officer, SCDHHS
Division Appeals & Hearings
P.O. Box 8206
Columbia, SC 29202
(803) 898-0594
(803) 255-8206(fax)
schindle@scdhhs.gov

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

November 29, 2011

CERTIFIED MAIL

Patricia Harrison, Esquire
Law Office of Patricia Harrison
611 Holly Street
Columbia SC 29205

RE: Fair Hearing of Albert Cooper Myers v. SCDHHS
Appeals' Case # 11-MISC-302 (MR/RD Waiver)

- NOTICE OF HEARING -

Dear Ms. Harrison:

We received an Order from the Administrative Law Court directing us to provide Mr. Myers with an evidentiary hearing within 60 days of November 9, 2011. I have scheduled the hearing for, **Friday, January 6, 2012, at 10:00AM, in the Ninth Floor Conference Room of the Jefferson Square Building, 1801 Main Street (corner of Main and Laurel), Columbia, South Carolina.** The hearing will be about the reduction and elimination of Mr. Myers' services under the Mental Retardation and Related Disabilities Waiver; specifically, the reduction of PCAII support, the elimination of home respite, physical therapy, occupational therapy, speech therapy and the denial of coverage for an augmented communication evaluation and equipment.

The rules for the hearing are enclosed in this letter. The rules and facts by which the Respondent denied the services will be forthcoming.

You should be ready to say why you think DHHS' decision is wrong. In presenting his case, you may look at his case file, call your own witnesses, ask questions of DHHS' witnesses, and give the Hearing Officer any papers you think are important.

If either, or both, parties intend to offer documents as evidence for entry into the record, then it will be necessary for that party(ies) to **make copies of the documents** so that the other party and the Hearing Officer may each have a copy of the document(s). Further, should either party as a part of their testimony intend to refer to a particular paragraph or section of a policy or procedure manual, directive, memorandum, etc., then it will be necessary for the party(ies) to **make copies in duplicate** of these referenced sections. Also, should either party intend to utilize charts, graphs, visual aids, etc., as a part of their presentation, then it will be necessary for that party to have these items **photocopied on 8 ½ x 11 inch paper** so that they may be easily integrated into the case record.

Division of Appeals and Hearings
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2600 • Fax (803) 255-8206

1010

If you cannot meet on the date above or have questions, and you live in the Columbia area, you may contact me at 898-2600; otherwise, if you live outside the Columbia area, you may contact me toll-free at 1-800-763-9087.

Sincerely,

Betsy Schindler

Betsy Schindler, Hearing Officer
Division of Appeals and Hearings

BS/sbs

Enclosure.

cc: Dr. Kathi Lacy, Ph.D., Associate State Director, Policy, SCDDSN
George Maky, Department Head, Community Waivers, SCDHHS
Kara Lewis, Bureau of Community Long Term Care Services, SCDHHS
Richard Hepfer, Office of General Counsel, SCDHHS
Deirdra Singleton, Deputy Director, Office of General Counsel, SCDHHS

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

February 9, 2012

CERTIFIED MAIL

Patricia Harrison Esquire
611 Holly Street

Columbia SC 29205

RE: Administrative Decision in the Appeal Matter of Albert Cooper Myers v. SCDHHS
Appeals' Case # 11-MISC-302 (MR/RD Waiver)

Dear Ms. Harrison Esquire:

The Administrative Decision in the referenced appeal matter is set forth in the enclosure.

Any party has the right to petition for further review of this Decision/Order, as provided in the Administrative Procedures Act [S.C. Code Ann. Section 1-23-310, et seq., (1976, as amended).] **To request an appeal, a Notice of Appeal must be filed with the Administrative Law Court, 1205 Pendleton Street, Brown Building – Suite 224, Columbia, S. C. 29201-3755 within thirty (30) days of receipt of this Decision/Order.** A copy of the Notice of Appeal should be provided to the S. C. Department of Health and Human Services' (SCDHHS) Office of General Counsel. The Notice of Appeal must be submitted in accordance with Rule 33 of the Rules of Procedure for the S.C. Administrative Law Court, which establishes specific requirements for the contents of a Notice of Appeal. Rule 35 directs that the party filing the Notice of Appeal is responsible for ordering the transcript and filing a copy of the request with the Notice of Appeal. The original request for transcript should be directed to the SCDHHS' Division of Appeals at the address below. **In accordance with the ALC rules, the cost of producing the transcript will be the responsibility of the party requesting appellate review.** For a copy of the ALC rules, you may contact the Administrative Law Court at (803) 734-0550.

Also, please see the enclosed Rule 71 of the Rules of Procedure for the ALC, which sets forth the required filing fee for an appeal.

Sincerely,

Robert French, Director
Division of Appeals and Hearings

RF/sbs
Enclosures (2)

From: Robert French
To: Patricia L Harrison; Rick Hepfer
Date: 2/26/12 12:12
Subject: [Secure] Re: Myers v. DHHS

Ms. Harrison,

Usually between 30 to 40 days after we receive the Notice of Assignment from the ALC.

Robert French, Director
Division of Appeals and Hearings
SC Dept. of Health & Human Services
P.O. Box 8206
Columbia, SC 29202-8206
(803) 898-2714
(803) 255-8206 (Fax)
frenchr@scdhhs.gov

>>> "Patricia L Harrison" <plh.cola@att.net> 2/26/12 11:45 >>>
Mr. French, we will be filing a notice of intent to appeal the Myers decision to the ALC. When will the transcript be available?

Thanks.

Trisha Harrison

From: Betsy Schindler
To: plh.cola@att.net; plh.cola@worldnet.att.net
CC: Rick Hepfer
Date: 2/28/2012 2:47 PM
Subject: Motion in matter of A.C.M.v. SCDHHS

Good Afternoon Ms. Harrison,

I received you motion dated 2/27/12 and your request for a transcript of the hearing. Because your motion was timely, the time for all parties to appeal should be stayed per Rule 59 (f). Normally, we prepare the transcript once we have received notification from the ALC that an appeal has been filed. I will be happy to make you a copy of the hearing recording, which you can have transcribed, if you provide a flash drive, If you choose to have the recording transcribed and if you provide me a copy, I would be willing to review and certify it, rather than wait for the ALC notice.

Betsy Schindler
Hearing Officer, SCDHHS
Division Appeals & Hearings
P.O. Box 8206
Columbia, SC 29202
(803) 898-0594
(803) 255-8206(fax)
schindle@scdhhs.gov

79.8292

RECEIVED FEB 0 9 2010

The Supreme Court of South Carolina

DANIEL E. SHEAROUSE
CLERK OF COURT

BRENDA F. SHEALY
CHIEF DEPUTY CLERK

POST OFFICE BOX 11330
COLUMBIA, SOUTH CAROLINA 29211

(803) 734-1080

FAX (803) 734-1499

February 4, 2010

Kenneth C. Anthony, Jr, Esquire
The Anthony Law Firm, PA
P.O. Box 3565
Spartanburg, SC 29304

Marjorie Taylor Elliott, Esquire
411 Meeting St.,6104
Charleston, SC 29403

Patricia Logan Harrison, Esquire
611 Holly St.
Columbia, SC 29205

Re: W., Karen, et al. v. Gov. Sanford

Dear Counsel:

The following Order has been endorsed on your Petition for Original Jurisdiction in the above entitled matter:

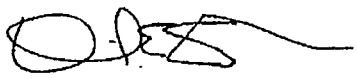
"Petition denied.

s/ Jean H. Toal C.J.
For the Court

February 04, 2010."

234

Very truly yours,



CLERK

DES/bfs

cc: E. Brandon Gaskin, Esquire
Swati Shah Patel, Esquire
The Honorable Converse Chellis
The Honorable Dan T. Cooper
The Honorable Henry D. McMaster
Chief Deputy Attorney General John W. McIntosh
The Honorable Hugh K. Leatherman
The Honorable Richard Eckstrom
William H. Davidson, II, Esquire
Andrew F. Lindemann, Esquire
Kenneth P. Woodington, Esquire
Vance J. Bettis, Esquire
Shahin Vafai, Esquire
Anderson M. Horne, Esquire
Anna Maria Darwin, Esquire
Nancy McCormick, Esquire
Sarah Garland St. Onge, Esquire
Franchelle C. Millender, Esquire
Mitchell C. Payne, Esquire

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Barbara Hickey, Appellant, vs. South Carolina Department of Health and Human Services, Respondent.	Docket No. 10-ALJ-08-0656-AP **FINAL ORDER AND DECISION**

STATEMENT OF THE CASE

This matter is before me pursuant to the appeal of Barbara Hickey (Appellant), from a final decision of the Respondent, South Carolina Department of Health and Human Services (DHHS or Department). This appeal is made in response to Respondent's January 1, 2010 cut in Personal Care Aide (PCA II) services to all those persons who, like the Appellant, rely on these services to live in the community and avoid institutionalization, and to Respondent's denial of Appellant's right to contest this withdrawal of necessary services at a hearing.

On December 1, 2009, Appellant received a letter from Respondent, stating that her in-home PCA II hours had been cut from 50 per week to 28 per week. Petitioner appealed that decision on January 15, 2010. Department of Disability and Special Needs (DDSN) responded to her appeal stating that the "limits cannot be exceeded and must be applied to all [Mental Retardation/Related Disabilities (MR/RD)] Waiver participants." Appellant appealed that decision on January 25, 2010. The hearing officer issued an "interlocutory order" dated January 29, 2010 which stated that she believed that the DHHS had the authority to administer the Medicaid Program in South Carolina, and that the Center for Medicare and Medicaid Services (CMS) had approved the revised Waiver, including the service caps. Petitioner responded on February 12, 2010 stating that she did not understand the decision and requesting a hearing. On

FILED
July 19, 2011
SC ADMIN. LAW COURT

February 17, 2010 the hearing officer dismissed appellant's case stating that she failed to respond to his Interlocutory Order with an allegation of error in fact or in law as ordered. On March 1, 2010, counsel for Appellant filed a Motion to Alter or Amend Judgment and a supporting Affidavit in response to the decision to dismiss Appellant's case and requested a fair hearing be held. On March 10, 2010, DHHS filed a Reply to Appellant's Motion requesting the hearing officer uphold its dismissal of Appellant's case and deny her a hearing. The hearing officer issued a final decision on July 20, 2010 dismissing Appellant's case without a hearing. Appellant received the final decision on July 28, 2010 and appealed to this Court on August 27, 2010. Both parties were represented by counsel at Oral Arguments on April 12, 2011 at the offices of the ALC in Columbia, South Carolina.

Issues on Appeal

1. Has the Department treated its PCA II benefit cap as a binding norm such that promulgation as a regulation is necessary for it to be enforceable?
2. Does inclusion in the waiver document make the PCA II cap enforceable without promulgation?
3. Does S.C. Code § 44-6-90 exempt the Department from promulgating regulations to carry out its duties?
4. Did the Department err in refusing to provide Hickey with a hearing?
5. Did the Department's decision contain erroneous findings of fact?

Standard of Review—

This matter is before the ALC in its appellate jurisdiction pursuant to S.C. Code Ann. § 1-23-600(D) (Supp. 2010). Accordingly, the Administrative Procedures Act's standard of review governs this appeal. See S.C. Code Ann. §§ 1-23-600(E), 1-23-380 (Supp. 2010); see also Byerly Hosp. v. S.C. State Health & Human Servs. Fin. Comm'n, 319 S.C. 225, 229, 460 S.E.2d 383, 385 (1995). The standard used by appellate bodies, including the ALC, to review agency decisions is provided by S.C. Code Ann. § 1-23-380(5) (Supp. 2010). This section provides:

> The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of

the agency or remand the case for further proceedings. The court may reverse or modify the decision [of the agency] if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

(a) in violation of constitutional or statutory provisions;
(b) in excess of the statutory authority of the agency;
(c) made upon unlawful procedure;
(d) affected by other error of law;
(e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
(f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-380(5) (Supp. 2010).

A decision is supported by "substantial evidence" when the record as a whole allows reasonable minds to reach the same conclusion reached by the agency. Bilton v. Best Western Royal Motor Lodge, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984). Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence that, considering the record as a whole, would allow reasonable minds to reach the conclusion the agency reached in order to justify its action. Hargrove v. Titan Textile Co., 360 S.C. 276, 289, 599 S.E.2d 604, 611 (Ct. App. 2004). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's finding from being supported by substantial evidence. Id.; Waters v. S.C. Land Res. Conservation Comm'n, 321 S.C. 219, 467 S.E.2d 913 (1996); Grant v. S.C. Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995). However, § 1-23-380(5) requires the reviewing tribunal to consider not only the amount of evidence, but also the quality of that evidence; it must be both "reliable" and "probative," as well as "substantial." See S.C. Code Ann. § 1-23-380(5) (Supp. 2010).

An abuse of discretion occurs when a decision is based upon an error of law, such as application of the wrong legal principle; or, when based upon factual conclusions, the ruling is without evidentiary support; or when the judge is vested with discretion, but the ruling reveals no discretion was exercised; or when the ruling does not fall within the range of permissible decisions applicable in a particular case. Ex Parte Capital U-Drive-It, Inc., 369 S.C. 1, 5, 630 S.E.2d 464, 467 (2006). A decision is arbitrary or capricious when no rational basis for the conclusion exists, when it is based on one's will and not upon any course of reasoning and

exercise of judgment. Converse Power Corp. v. S.C. Dep't of Health & Envtl. Control, 350 S.C. 39, 564 S.E.2d 341 (Ct. App. 2002); Deese v. S.C. State Bd. of Dentistry, 286 S.C. 182, 184-85, 332 S.E.2d 539, 541 (Ct. App. 1985). A decision may be arbitrary or capricious when it is made at one's pleasure without adequate determining principles, or is governed by no fixed rules or principles. Deese, 286 S.C. at 184-85, 332 S.E.2d at 341. Non-uniform, inconsistent, or selective application of authority can indicate arbitrariness. See Mungo v. Smith, 289 S.C. 560, 571, 347 S.E.2d 514, 521 (Ct. App. 1986).

Medicaid MR/RD Waiver Program

Medicaid is an optional state program created under Title XIX of the Social Security Act. It enables states to receive federal financial assistance specifically for the medical care of needy individuals. See 42 U.S.C.A. § 1396; Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007). States are not required to participate in Medicaid; however, if they choose to do so, they must comply with all federal Medicaid laws and regulations. Wilder, 496 U.S. 498; Doe, 501 F.3d at 351; see also Antrican v. Odom, 290 F.3d 178 (4th Cir. 2002) ("Although North Carolina may retain a special sovereignty interest in choosing whether to participate in the Medicaid program, once it elects to participate, it is not entitled to assert that interest to insulate itself from the requirements of the federal program."), cert. denied, Odom v. Antrican, 537 U.S. 973 (2002). As a prerequisite to receiving federal assistance, a state must submit a detailed plan, referred to as the "State Plan," to the CMS for approval. 42 U.S.C.A. § 1396a.

In South Carolina, DHHS is the state agency responsible for administering and supervising the state's Medicaid programs. S.C. Code Ann. § 44-6-30(1); Doe, 501 F.3d at 351. DDSN is responsible for the state's treatment and training programs for people with mental retardation and related disabilities. Doe, 501 F.3d at 351. Accordingly, in some instances, such as the case at hand, DDSN can act as an agent for DHHS. Id.

Medicaid normally provides funding for individuals with mental disabilities who live in an institution. However, states may make a request to the CMS for a "waiver" to pay for otherwise non-covered Home and Community Based Services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized as long as the services are cost effective. 42 U.S.C.A. § 1396n(c).

States must seek approval for these waiver programs from the CMS. If a waiver is approved, the CMS waives compliance with state program requirements while permitting states to remain eligible for reimbursement with federal grants. Id. The waiver program provides Medicaid reimbursement to participant states for providing HCBS to individuals who would otherwise require institutional care. See 42 U.S.C.A. § 1396n(c). Waivers are approved for a period of two to three years and may be renewed thereafter. Under a program operated by DDSN, CMS has waived the requirement that an individual live in an institution to receive services. In this appeal, the waiver program at issue is the MR/RD Waiver Program. The MR/RD Waiver Program permits a recipient to receive services at home or in the community, rather than in an Intermediate Care Facility Mental Retardation (ICF/MR) such as a nursing home. Doe, 501 F.3d at 351.

On January 1, 2010 a new MR/RD waiver renewal became effective following approval by CMS. The renewed waiver document includes a cap of 28 hours per week for PCA II services. PCA II services consist of hands-on personal care to help a participant accomplish the activities of daily living such as bathing, toileting, dressing and eating.

I. Has the Department treated its PCA II benefit cap as a binding norm such that promulgation as a regulation is necessary for it to be enforceable?

The central issue raised by the Appellant in this case is whether the Department is entitled to rely on an amendment to the MR/RD waiver document to cut Appellant's PCA II services from 50 to 28 hours per week. It is uncontroverted that the cap on PCA II services was not promulgated as a regulation under the Administrative Procedures Act, S.C. Code Title 1, Chapter 23 (APA). The Department makes three arguments in support of its position that it properly applied the cap on PCA II services in this case without promulgating the cap provision as a regulation.

The Department first asserts that the cap on CPA II services is not a rule that must be promulgated as a regulation in order to be enforceable. "[W]hether an agency's action or statement amounts to a rule--which must be formally enacted as a regulation -- or a general policy statement -- which does not have to be enacted as a regulation -- depends on whether the action or statement establishes a 'binding norm.'" Sloan v. S.C. Bd. of Physical Therapy Exam'rs, 370 S.C. 452, 636 S.E.2d 598 (2006). In order for an agency to create a "binding" rule

it must be promulgated as a regulation. Home Health Serv., Inc. v. S.C. Tax Comm'n, 312 S.C. 328, 440 S.E.2d 375 (1994). The key factor in determining whether a policy statement establishes a "binding norm" is the extent to which the challenged policy leaves the agency free to exercise its discretion to follow or not follow the policy at issue in a particular situation. Home Health Serv. Inc. v. S.C. Tax Comm'n, 312 S.C. 324, 328, 440 S.E.2d 375, 378 (1994). If the policy at issue "so fills out the statutory scheme" that the agency will only look to whether the policy's criteria are met in taking action or rendering a decision, the policy will be considered a "rule" or "regulation." Id. As long as the agency remains free to consider the individual facts in taking action or rendering a decision, the policy at issue will not be considered a "binding norm." Id. Thus, to determine whether a policy or guideline establishes a "binding norm," courts look to the actions of the agency, not to the labels given by the agency.

In this case, the Department argues that it has not treated the cap on PCA II services as a binding norm. I find no support for this argument in the record; the Department has consistently treated the PCA II services cap as a binding norm. In its initial letter denying Hickey's request for continued PCA II services benefits at the level she formerly received, the Department stated,

> [L]imits or caps were placed on services in the MR/RD Waiver. Approval for these limits or caps was obtained from the [CMS]. These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants. While we understand and appreciate the hardship these changes may place on you, we are not at liberty to exceed the established limits.

In response to Hickey's appeal of that decision, the hearing officer upheld the Department's decision denying Hickey a hearing in part because, the Department

> need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients. The reduction in Petitioner's PC II hours was imposed by caps and limits on these, and other services specified in the MR/RD Waiver as renewed effective January 1, 2010, and imposed upon all Waiver participants. These changes in the Waiver were approved in advance by ...CMS....For the purposes of this decision, it is presumed that this approval, inclusive specifically of the changes approved, by CMS carries the force and effect of law.

Thus, because the Department's decisions in this case look only to whether the services Hickey received were within the cap and not to any other standard or factual issues, the cap on PCA II services was treated as a binding norm and not as a general policy statement. The Department did not treat the cap as a policy statement that it was free to exercise its discretion to

follow or not follow according to the particular facts in Hickey's situation. See Ryder, 717 F.2d at 1377-1378.

II. Does inclusion in the waiver document make the PCA II cap enforceable without promulgation?

The Department next argues that it is not required to promulgate the provisions of the waiver document in order to enforce them because they are a contract between the state and federal government contemplated by the agency statutes and regulations and are entitled to deference as a "federal directive."[1] The Department cites its regulation S.C. Code Ann. Regs. 126-300 and its general grants of authority contained in S.C. Code Ann. § 44-6-30 to 40 in arguing that the PCA II service cap should be enforced.

I find no legal support for this argument. On the contrary, other states which have considered this precise question have held that the provisions of a waiver document must be promulgated as regulations under the state's APA in order to be enforceable as a rule or binding norm. In McCrann v. N.C. Dept. Health and Human Services, 704 S.E.2d 899 (N.C. App. 2011), the North Carolina Court of Appeals held that it was error of law for the agency to rely upon the provisions of a waiver to deny services to a Medicare beneficiary. The court held that the provisions of the waiver limiting benefits were "rules" that must be promulgated as regulations pursuant to the state APA in order to carry the force of law. Likewise, in Hoban v. State of Vermont, Op. No. 200-4-05, Lexis 40 (Vt. Super 2005), the Superior Court of Vermont held that a cap on HCBS contained in a Medicaid waiver program was void due to the agency's failure to promulgate the cap as a regulation under the state APA. See also, Mullins v. N. Dakota Dept. of Human Services, 454 N.W.2d 732 (N.D. 1990) (invalidating unpromulgated manual provisions purporting to define individuals eligible for benefits). Compare, Rennich ex rel. Rennich v. N. Dakota Dept. of Human Services, 2008 ND 171, 756 N.W.2d 182, 188 (N.D. 2008) (distinguishing situation where conditions of eligibility are set by federal statute and regulation).

III. Does S.C. Code § 44-6-90 exempt the Department from promulgating regulations to carry out its duties?

[1] For purposes of this discussion I assume without deciding that the Department's characterization of the waiver document as a "federal directive" is accurate. It appears that the waiver document was authored by the Department and approved by the federal agency, CMS.

Lastly, the Department asserts that South Carolina statutes do not require the Department to promulgate regulations to carry out its duties. In support of this position the Department cites S.C. Code Ann. § 44-6-90, which states, "The department may promulgate regulations to carry out its duties." The Department's argument is that because § 44-6-90 allows, but does not require, the Department to promulgate regulations, that the Department is exempt from the requirements of the APA when carrying out its duties. In South Carolina the cardinal rule of statutory interpretation requires the trier of fact to ascertain the intent of the legislature. State v. Scott, 351 SC 584, 588, 571 S.E.2d 700, 702 (2002). In doing so, the court must give a reasonable and practical construction to the statute that is consistent with the purpose and policy expressed in the statute. Davis v. NationsCredit Fin. Servs. Corp., 326 SC 83, 484 S.E.2d 471 (1997). Where there is one statute addressing an issue in general terms and another statute dealing with the issue in a more specific and definite manner, the more specific statute will be considered an exception to, or a qualifier of, the general statute and given such effect. Capco of Summerville, Inc. v. Gayle Construction Company, Inc., 368 S.C. 137, 628 S.E.2d 38 (2006). Statutes in apparent conflict should, if reasonably possible, be construed so as to allow both to stand and to give effect to each. Higgins v. State, 307 S.C. 446, 449, 415 S.E.2d 799, 801 (1992). I conclude that the general language allowing the Department to promulgate regulations does not override the more specific requirements of the APA. To interpret Section 44-6-90 as urged by the Department would imply that every agency given general authority to promulgate regulations is thereby exempted from the 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 and enforceable rule without promulgating the cap as a regulation pursuant to the APA.

IV. Did the Department err in refusing to provide Hickey with a hearing?

The procedures for appealing a decision regarding Medicaid services provided under a HCBS waiver are set forth in the Code of Federal Regulations. See 42 C.F.R. §§ 441.200 *et. seq.* Those regulations provide that a state hearing system for Medicaid recipients under a state waiver "must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970)." 42 C.F.R. § 431.205(d). The state agency must grant an opportunity for a hearing to any applicant who requests it because his claim for services is denied, 42 C.F.R. § 431.220(a)(1),

or if the state agency takes action to suspend, terminate or reduce services. 42 C.F.R. § 431.200(b). However, the agency need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients. 42 C.F.R. § 431.220(b). As a state agency administering the Medicaid program, the Department must comply with all federal Medicaid laws and regulations. Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007).

The Department advances two arguments in support of its dismissal of Hickey's matter without a hearing. First, the Department argues that the reduction of benefits carried out pursuant to the revised waiver's cap on PCA II services is an issue involving a change in state or federal law and so no hearing is required pursuant to 42 C.F.R. § 431.220(b) (stating that the agency need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients). I am unpersuaded by this argument because, as discussed in detail above, the PCA II cap contained in the revised waiver document does not have the force and effect of law. Thus, Hickey's request for a hearing does not fall within the exception to the hearing requirement provided by 42 C.F.R. § 431.220(b).

Second, the Department argues that the process afforded Hickey met the requirements of Due Process and the federal regulations because the Department offered Hickey an opportunity to present written argument in response to the interlocutory order. The Department argues that because Hickey responded to the interlocutory order by requesting a hearing rather than by submitting written statements demonstrating a "valid factual dispute" that she failed to avail herself of the opportunity the Department offered for a hearing. The Department cites Rosen v. Goetz, 410 F.3d 191 (6th Cir. 2005) in support of its argument that only an opportunity for a written argument is minimally required in some cases. Because the Rosen case arose in the context of a challenge of a procedure by hundreds of plaintiffs concerned with the enforcement of a consent order and not in the context of an individual request for a hearing preceeding a reduction in Medicaid benefits, I find the reasoning contained therein insufficient to overcome the hearing requirements applicable to this case pursuant to the controlling federal regulations and the standard enunciated by the Supreme Court in Goldberg. The Goldberg Court held:

> The city's procedures presently do not permit recipients to appear personally with or without counsel before the official who finally determines continued eligibility. Thus a recipient is not permitted to present evidence to that official orally, or to

> confront or cross-examine adverse witnesses. These omissions are fatal to the constitutional adequacy of the procedures. The opportunity to be heard must be tailored to the capacities and circumstances of those who are to be heard. It is not enough that a welfare recipient may present his position to the decision maker in writing or second-hand through his caseworker. Written submissions are an unrealistic option for most recipients, who lack the educational attainment necessary to write effectively and who cannot obtain professional assistance. Moreover, written submissions do not afford the flexibility of oral presentations; they do not permit the recipient to mold his argument to the issues the decision maker appears to regard as important....Therefore a recipient must be allowed to state his position orally.

Goldberg v. Kelly, 397 U.S. 254, 268- 269, 90 S. Ct. 1011, 1021, 25 L. Ed.2d 287 (1970). The controlling federal regulations specifically require the Department to "meet the due process standards set forth in Goldberg." 42 C.F.R. § 431.205(d). Moreover, federal regulations require the Department to grant an opportunity for a hearing to any applicant who requests it because his claim for services is denied, 42 C.F.R. § 431.220(a)(1), or if the state agency takes action to suspend, terminate or reduce services. 42 C.F.R. § 431.200(b). Because the Department seeks to reduce Hickey's benefits and she requested a hearing, it was error for the Department to deny her a hearing. It was not enough to demand that she present issues of fact in writing and to dismiss her appeal when she requested an in-person hearing. Moreover, where a case involves important questions of novel impression, such as the issues presented here concerning the enforceability of the unpromulgated waiver document and the issues of compliance with the Americans with Disabilities Act currently pending in federal district court,[2] it is error to dismiss the case for failure to state a claim. Evans v. State Retirement, 344 S.C. 60 543 S.E.2ed 547 (2001).

V. Did the Department's decision contain erroneous findings of fact?

Appellant raises several additional issues concerning whether findings of fact and recitations of the history of the proceedings contained in the Department's decision are erroneous. Although I note the lack of support in the record for the challenged findings and statements, the consideration of the remaining issues is unnecessary because the Department's decision is reversed on the grounds discussed above. See Futch v. McAllister Towing of Georgetown, Inc., 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999) (concluding that an appellate

[2] Hickey v. Forkner, 4:10-CV-02696-TLW-TER (D.S.C. 2010)

court need not address remaining issues when disposition of a prior issue is dispositive of the case).

ORDER

IT IS HEREBY ORDERED that, the Decision of the South Carolina Department of Health & Human Services reducing Appellant's PCA II services from 50 hours per week to 28 hours per week is **REVERSED.**

IT IS FURTHER ORDERED that before taking further action to reduce Appellant's benefits under the MR/RD waiver, the Department must provide Appellant with a hearing consistent with this Order and Decision; the benefit limitations contained in the January 1, 2010 MR/RD waiver renewal may not serve as the legal basis for a reduction in benefits unless they are promulgated pursuant to the requirements of the South Carolina Administrative Procedures Act.

AND IT IS SO ORDERED.

Deborah Brooks Durden
Administrative Law Judge

July 19, 2011
Columbia, South Carolina

FINAL ADMINISTRATIVE ORDER IN THE APPEAL MATTER OF
D.L.B. (PETITIONER) v. SCDHHS (RESPONDENT)

Appeals' Case #11-MISC-156 (MR/RD Waiver)
Hearing Date: August 11, 2011

JURISDICTION

Procedure in this case is governed by the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services to administer various programs and grants (See e.g., S.C. Code Ann. 44-6-10, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (Reg. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. 1-23-310, et seq.).

PROCEDURAL HISTORY

The Respondent's, South Carolina Department of Health and Human Services' (SCDHHS'), agent, South Carolina Department of Disabilities and Special Needs (SCDDSN), sent the Petitioner's Adult Day Health Care (ADHC) provider, HopeBridge Inc., a Notification of Termination of Services dated April 15, 2011. The Notification informed the provider that they would only be allowed to bill for services rendered on or before May 1, 2011 because the Petitioner's ADHC was being terminated as he no longer met criteria for ADHC. A copy of this notice was sent to the Participant/legal guardian with an explanation of the SCDDSN reconsideration process and the SCDHHS appeals process. The Petitioner's representative/mother filed a reconsideration request with SCDDSN and received the reply in an unsigned letter dated April 27, 2011. The initial termination of the Petitioner's ADHC was upheld upon reconsideration. On May 18, 2011, the SCDHHS, Division of Appeals and Hearings received a request for a Fair Hearing from the Petitioner's mother in this matter.

A hearing was convened on August 11, 2011. The Petitioner was present and was represented by Jack E. Cohoon, Esq. In addition, in attendance for the Petitioner were his mother, sister and Susan Penland, RN of Hope Bridge. Richard Hopfer, Esq represented the Respondent. Also in attendance for the Respondent were Jacob Chorey, MR/RD Waiver Coordinator at SCDDSN, Tamara Friday, Service Coordinator, SCDDSN and Kara Lewis, SCDHHS, Division of Community Long Term Care. Observing the hearing was Robert French, SCDHHS, Director, Division of Appeals and Hearings. All parties were present for the entire hearing with the exceptions of Ms. Penland who left without giving testimony and Ms. Friday who left after giving testimony.

ISSUE

The issue(s) of merit in this matter concern: whether SCDHHS (Respondent) and its agent, SCDDSN correctly terminated the Petitioner's ADHC services in accordance with

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applicable regulations and policy guidelines. Any issues raised in the proceedings or hearing of this case but not addressed the Decision are deemed denied.

FINDINGS OF FACT

Having observed the witnesses and exhibits presented at the hearing and closely passed upon their credibility, and considering the burden of persuasion by the parties, I make the following Findings of Fact by a preponderance of the evidence:

(1) The Petitioner is a forty-six year old participant in the Intellectual Disability/Related Disability Waiver (ID/RD) (formerly referred to as the Mental Retardation/Related Disabilities Waiver) who has been receiving ADHC services from HopeBridge for approximately eleven years, and I so find; (Petitioner's exhibit #3 and Respondent's exhibit #1)

(2) To be eligible to receive ADHC services through the ID/RD Waiver, participants must be found to require extensive assistance in at least one of three areas: (1) locomotion/transfer, (2) dressing, toileting and eating, (3) incontinence care; or have a complex medical condition which requires assistance as specified on the Adult Day Health Care Assessment of Need form (MR/RD Form AA), and I so find; (Respondent's exhibit #1)

(3) On January 19, 2011, the Respondent assessed the Petitioner's needs and found he did not meet the requirements to continue to receive ADHC, and I so find; (Respondent's exhibit #1)

(4) HopeBridge received a Notification of Termination, dated April 15, 2011, relating that "the consumer (Petitioner) no longer meets criteria for ADHC services and will be moved to an appropriate day service per DDSN policy". Direction was given to bill only the number of units rendered prior to or on the effective date of May 1, 2011, and I so find; (Petitioner's exhibit # 3)

(5) The Petitioner's mother requested reconsideration of the pending termination of ADHC with SCDDSN, and I so find;

(6) Via unsigned letter dated April 27, 2011, SCDDSN upheld the decision to terminate ADHC services because the Petitioner has neither a deficit in one of the specifically defined functional ability categories nor a medically complex condition that would qualify him, and I so find; (Petitioner's exhibit # 1 and Respondent's exhibit #1)

(7) The Petitioner, through his mother, filed an appeal of the SCDDSN reconsideration decision with SCDHHS Division of Appeals and Hearings on May 18, 2011, and I so find; (Petitioner's exhibit # 1 and Respondent's exhibit #1)

(8) Petitioner's representative's testimony asserted Harmon F. Patrick, M.D. is the Petitioner's primary care physician, and I so find; (Petitioner testimony)

(9) Per Affidavit of Dr. Harmon Patrick, sworn August 8, 2011, the Petitioner's physical abilities are declining, which have increased his gait instability as well as weakness which has lead to increased incidents of falling, and I so find; (Respondent's exhibit #1)

(10) While the Respondent's assessment in January 2011, based on available records from medical and service providers, conversations with the Petitioner's mother and service providers and personal observations, may have been credible for the Petitioner's condition at that time, current evaluation by his physician, testimony of the Petitioner's mother and sister and observation of the Petitioner at the Hearing by the Hearing Officer makes evident the Petitioner does require extensive assistance with locomotion, therefore, the Petitioner does meet the criteria to continue receiving ADHC services through the MR/MR Waiver, and I so find;

APPLICABLE LAW

(1) "A Hearing Officer has the authority, among other things, to: direct all procedures, issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or conclusions of law; call witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with the requirements of this subarticle." South Carolina Department of Health and Human Services, Chapter 126, "Administration" R.126-154, §44-6-90, S.C. Code, 1976, as amended.

(2) 42 CFR §431.55 authorizes South Carolina to request additional Medicaid services to recipients not otherwise furnished under South Carolina's State Medicaid plan, or to "waive" those requirements of section 1902 of the Social Security Act as long as these additional services to recipients under Medicaid are cost effective, efficient, and consistent with the objectives of the Medicaid program. These additional services in South Carolina are included in the Home and Community Based Services Waiver programs.

(3) 42 CFR §440.180 directs that Home and Community Based Services may consist of any or all of the following services: case management services, homemaker services, home health aide services, personal care services, adult day health services, habilitation services, respite care services, day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, and other services requested by the Medicaid agency and approved by Centers for Medicare and Medicaid Services (CMS) as cost effective and necessary to avoid institutionalization.

(4) 42 CFR § 431.210 directs the Respondent when issuing its notice at the time of any action that affects a Medicaid applicant's or recipient's Medicaid benefits and reads as follows:

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Sec. 431.210 Content of notice.

A notice required under Sec. 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.

(5) 42 CFR § 431.211 requires the Respondent to mail a notice of adverse action to a Medicaid recipient at least ten (10) days before the date of action.

(6) South Carolina Department of Disabilities and Special Needs website- http://ddsn.sc.gov/providers/medicaidwaiverservices/mrrd/Documents/Default/MR_RD%20Waiver%20Manual%20Chapter%2010%20%28Adult%20Day%20Health%20Care%20Services%29.pdf

ADULT DAY HEALTH CARE SERVICES (age 21 and over)

Definition: Services furnished 5 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. The State intends to limit services to participants with medically complex conditions, or participants who require extensive assistance with functional activities/tasks, as determined by DDSN assessment. Authorization of services will be based on the participant's need for the service as identified and documented in his/her Support Plan. Meals provided as part of this service shall not constitute a full nutritional regime (3 meals per day). Physical, occupational and speech therapies indicated in the participant's Support Plan are not furnished as component parts of this service.

The unit of service is one "participant day," which is a minimum of 5 hours of a day, exclusive of transportation. The unit of service will be a minimum of 4 hours when the participant has a scheduled medical appointment requiring him or her to leave early or arrive late.

Please see Scope of Services for Adult Day Health Care Services.

Providers: Centers/agencies contracted with SCDHHS to provide Adult Day Health Care Services under the MR/RD Waiver. These centers/agencies are listed on the Adult Day Health Provider Listing or you may contact your supervisor if you have questions about a center's/agency's enrollment status.

Arranging for and Authorizing Services: Adult Day Health Care services are only appropriate for those MR/RD Waiver participants who are at least 21 years of age and who, due to functional ability or medical condition, will not benefit from traditional SCDDSN Day Service options. If the Service Coordinator suspects that Adult Day Health Care services may be needed; or if these services are requested by the participant or his/her family, the Adult Day Health Care Assessment of Need (MR/RD Form AA) should be used to determine if Adult Day Health Care Services are appropriate. This form must be completed and the need for services indicated before Adult Day Health Care Services can be provided.

Note: If a participant who is under age 21 began receiving the service prior to 1 January 2010, he/she may continue to receive the service, as long as the assessed need is present. After 1 January 2010, no one less than 21 years of age may be authorized to receive the Adult Day Health Care services.

Note: If the intended participant is currently enrolled in the CLTC Community Choices Waiver and receiving Adult Day Health Care Services, he/she may or may not be able to continue this service under the MR/RD Waiver. The Adult Day Health Care Assessment of Need (MR/RD Form AA) must be completed and submitted to SCDDSN District Office along with supporting documentation. If the intended participant meets the Assessment of Need and the need for Adult Day Health Care is supported by his/her Support Plan and other submitted documentation, then he/she will be able to receive this service through the MR/RD Waiver. Typically this type of review is done when submitting the budget. Since this may determine if a person will transition from the CLTC Community Choices Waiver to the MR/RD Waiver, the Service Coordinator may notify the District MR/RD Waiver Coordinator to request a preliminary review and decision prior to MR/RD Waiver enrollment.

Once it is determined that Adult Day Health Care services are needed, the Service Coordinator should document the need for the services in the participant's Support Plan and offer the participant or his/her family choice of providers. The Service Coordinator should document this offering of choice.

ADHC Once the amount and the frequency of the service have been determined and the family has selected a provider, the chosen provider should be contacted to determine space/service availability. Also, at this point, budget information can be entered into the Waiver Tracking System. Once the budget is entered, the completed Adult Day Health Care Assessment of Need (MR/RD Form AA) and supporting documents (e.g. Support Plan, medical assessments, psychological evaluation, etc.), if not previously submitted, must be forwarded to the District MR/RD Waiver Coordinator. The supporting documents should include information that reinforces the assessment of need.

Once the service is approved by District Office, the Service Coordinator may authorize the service. Services must be authorized using the Authorization for Adult Day Health Care Services (MR/RD Form A-23).

Once the center/agency receives the completed Authorization for Adult Day Health Care Services (MR/RD Form A-23), it must negotiate the start date with the Service Coordinator. The Authorization for Adult Day Health Care Services (MR/RD Form A-23) will remain in effect until a new form changing the authorization is provided to the Adult Day Health Care center/agency or until services are terminated.

Prior to starting the service, the Adult Day Health Care center/agency must obtain the Community Long Term Care Adult Day Health Care Form (DHHS Form 122 DC) from the physician.

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Monitoring Services: The Service Coordinator must monitor the service for effectiveness, usefulness and participant satisfaction. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following guidelines should be followed when monitoring Adult Day Health Care Services:

- During the first month of service, monitoring should be conducted while the service is being provided.
- Services should be monitored at least once during the second month of service.
- Services should be monitored at least quarterly (i.e. within 3 months of the previous monitoring) thereafter.
- Monitoring should start over as if it is the start of service any time there is a change of provider.
- Monitoring should be conducted on-site at least once annually (i.e. within 365 days of the previous on-site monitoring).
- Except for the initial monitoring, this service may be monitored during a contact with the participant/family or service provider. It may also occur during review of written documentation at the Adult Day Care Center or during an on-site visit.

Some questions to consider during monitoring include:

- Is the participant satisfied with the Adult Day Health Care Center?
- Is the ADHC Center clean (sanitary)?
- Is the ADHC Center in good repair?
- How often does the participant attend?
- Are there any health/safety issues?
- How often does the ADHC Center staff have contact with family?
- Are there any behavior problems?
- What types of recreational activities does the person participate in?
- What types of recreational activities does the ADHC Center offer?
- Does the participant feel comfortable interacting with staff?
- What are the opportunities for choice given to the participant?
- What type of care is the participant receiving?

ADHC

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

DISSCUSSION AND CONCLUSIONS OF LAW

The predominant issue in this matter is whether the Petitioner meets DDSN's criteria to qualify for continued ADHC services. The Respondent testified that when the Petitioner originally qualified for ADHC, the justification for service was solely at the primary care physician's discretion. Over time it became evident to DDSN that physicians tended to order what the participant's families requested and not necessarily what they medically required. To remedy this, DDSN changed their policy to require Service Coordinators to assess each participant by reviewing the medical records and service provider notes, making personal observations and initiating conversations with family and care givers to inquire about the participants services and needs to complete an assessment. Unfortunately, in this case, the records do not appear to reflect the Petitioner's true condition at the time of the assessment and certainly do not reflect his current health status. Complex medical conditions have contributed to the Petitioner's declining health which has resulted in increased weakness, possibly due to dyskinesia and dramatic weight loss over the last several years. His ability to walk independently or with little assistance has also declined drastically as his tendency to fall frequently demonstrates. While I commend the Respondent and its agent for their efforts to ensure their clients receive services which are necessary to maintain optimum health, in this instance, I find the Petitioner does meet at least one functional ability requirement; extensive assistance with locomotion, thus qualifies to continue to receive ADHC services.

—*Conclusion of Law: the Hearing Officer's evaluation of policy, testimony and evidence submitted, leads to the conclusion the Petitioner continues to meet the requirements for ADHC services as presented in the* South Carolina Department of Disabilities and Special Needs, Intellectual Disability/Related Disability Waiver Policy for the Waiver Policy & Procedures Manual.

While the main issue of the Hearing was whether the Petitioner qualified to continue receiving ADHC services, several issues were raised. Whether DDSN failed to provide proper notice of the termination of ADHC benefits was broached. Review of the DDSN Notification of Termination of Service does find it regrettably 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. It appears the "Participant/legal guardian" was sent a copy of the letter but it does not specify to whom the letter was sent. In addition,

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the letter relaying the decision of the reconsideration also failed to cite regulations that supported the negative action and neither copy of this letter in the file displayed a name or signature from the official making the final decision.

—Conclusion of Law: The Respondent's Notification of Termination of Service and reconsideration notice did inform what action the Medicaid agency intended to take and provided rather cryptic reasons for the action. The notices were deficient in that they did not indicate the specific regulations that support the termination of ADHC services pursuant to 42 CFR § 431.210, but, as the Petitioner's representative did perceive their appeal rights and filed a timely appeal, any deficiencies the notices may exhibit did not harm the Petitioner's ability to request or have a Fair Hearing.

Lastly, the Petitioner's counsel argues that terminating the Petitioner from receiving ADHC could be a breach of the Americans with Disabilities Act (ADA) as this Act dictates that persons with disabilities be placed in the most integrated setting possible. I do not find this argument convincing since DDSN expounded on their intentions to consider authorizing services for the Petitioner in Adult Day Service, a DDSN program which is also offered at HopeBridge and is offered in an integrated setting.

—Conclusion of Law: The Petitioner's counsel has provided no objective evidence of a violation of the Americans with Disabilities Act (ADA), pursuant 28 CFR 35 appendix A. The Respondent's decision to terminate the Petitioner's ADHC services was not a violation of the ADA as DDSN's stated intentions were to authorize services under another DDSN Day program which is less restrictive and is in a more integrated setting than the Petitioner's current program.

DECISION

Based on the Findings of Fact, Applicable Law and Discussion and Conclusions of Law, the SCDDSN termination of the Petitioner from ADHC services and the SCDDSN April 27, 2011 reconsideration decision(s) are hereby REVERSED.

AND IT IS SO ORDERED.

Betsy Schindler

Betsy Schindler
Hearing Officer

DATED AT COLUMBIA,
South Carolina
August 15, 2011

Doe v. South Carolina Department of Health and Human Services, 27083 (SCSC)

Jane Doe, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

No. 27083

Supreme Court of South Carolina

December 28, 2011

Heard: November 3, 2010

Appeal from Richland County Paige J. Gossett, Administrative Law Court Judge

Patricia Logan Harrison, of Columbia, and Stuart M. Andrews, Jr. and Jennifer I. Cooke, Nelson Mullins Riley & Scarborough, both of Columbia, for Appellant.

William H. Davidson, II, and Kenneth P. Woodington, Davidson & Lindemann, both of Columbia, for Respondent.

KITTREDGE, JUSTICE

This appeal presents the question of whether Respondent South Carolina Department of Health and Human Services and its agent, the South Carolina Department of Disabilities and Special Needs (DDSN), "properly ceased Mental Retardation/Related Disability services to" [1] Appellant Jane Doe, a twenty-eight-year-old woman with undeniable cognitive and adaptive deficits. Based on a purported legal standard that the "onset of Mental Retardation must be before the age of eighteen (18) years according to accepted psychological doctrine[,]" the Hearing Officer concluded Doe was not mentally retarded. The Administrative Law Court (ALC) affirmed this legal determination, as well as the Hearing Officer's factual findings. Because the decision of the Hearing Officer and ALC is controlled by an error of law, we reverse and remand.

I.

BACKGROUND

A.

Medicaid is a program through which the federal government, through the Social Security Administration (SSA), provides financial assistance to states so that they may furnish medical care to needy individuals. *Wilder v.*

2. The person's needs are such that supervision is necessary due to at least one of the following: impaired judgment, limited capabilities, behavior problems, abusiveness, assaultiveness or because of drug effects/medical monitorship.

AND

3. The person is in need of services directed toward a) the acquisition of the behaviors necessary to function with as much self-determination and independence as possible; or b) the prevention or deceleration of regression or loss of current optimal functional status.

Attachment 1 to Appendix D-3, South Carolina's Mental Retardation/Related Disabilities (MR/RD) Waiver Document (Effective October 1, 2004-September 30, 2009).

The second and third eligibility criteria are commonly referred to collectively as "Level of Care." These criteria describe the minimum services and functional deficits necessary to qualify for Medicaid-sponsored institutional care in an ICF/MR. South Carolina's waiver application provides that Level of Care reevaluations will take place at least every twelve months. [4] Appendix D-2, South Carolina's Mental Retardation/Related Disabilities (MR/RD) Waiver Document (Effective October 1, 2004-September 30, 2009). South Carolina's waiver application with the federal government does not include any age-of-onset requirement and reveals no intent to vary from or otherwise limit the group of individuals encompassed by the SSI definition of mental retardation. On the waiver application in effect in 2005, South Carolina checked letter "f, " thereby expressing its intent to provide waiver services to the group identified as "mentally retarded persons and persons with related disabilities." In addition, where asked whether it would impose any "addition[al] targeting restrictions" on the provision of waiver services, South Carolina stated "Not applicable."

In 1990, the South Carolina General Assembly adopted a definition of mental retardation that parallels the SSI definition adopted by the federal government in 1985. *See* Act. No. 496, 1990 S.C. Acts 2184, 2187; 50 Fed. Reg. 35038, 35068-69 (Aug. 28, 1985). The definition, codified at South Carolina Code section 44-20-30, states that mental retardation is "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." [5] The term "developmental period" was new to the 1990 definition, and it is upon the construction of that term that this matter largely turns.

DDSN promulgated a regulation which recites the SSI/44-20-30 definition of mental retardation (with only minor changes in phrasing) and defined the term "developmental period" as the period from conception to age twenty-two, consistent with the SSI definition. [6] 26 S.C. Code Ann. Regs. 88-210(F) (Supp. 2010). Thus the definition of mental retardation under state law "Regulation 88-210(F)" mirrors the SSI definition with respect to the age-of-onset requirement. No South Carolina regulation imposes additional diagnostic criteria for mental retardation in the context of waiver services. Nevertheless, DDSN attempted through a "Policy of Determination of Eligibility" to impose more restrictive diagnostic criteria for mental retardation for eligibility for waiver services in the form of an age-eighteen-onset requirement for mental retardation. The policy states:

> DDSN evaluates referred individuals in accordance with the *definitions of Mental Retardation outlined in the American Psychiatric Association's Diagnostic and Statistical Manual* of Mental Disorders -Fourth Edition (DSM-IV, 1994) and the *American Association on Mental Retardation* (AAMR 9th Edition, 1992).
>
> Mental Retardation refers to substantial limitations in present functioning. *Diagnosis of mental retardation based on the DSM-IV and AAMR definitions* requires the following three criteria be met:

....

3. *The onset of mental retardation is before age 18 years.*

South Carolina Dep't of Disabilities and Special Needs Policy for Determination of Eligibility Guidelines to Operationalize Eligibility Policy (Effective July 1, 1998) (emphasis added). [7]

II.

FACTUAL/PROCEDURAL HISTORY

Jane Doe was born on March 24, 1983, the product of an indisputably complicated birth. She was born at thirty weeks gestation, weighing just two pounds, three ounces. At ten months old, she was diagnosed with cerebral palsy, and her doctors diagnosed her with a seizure disorder at age eleven. As a result of her conditions, she has limited use of her left hand, difficulty with balance, and an awkward gait. Additionally, Doe presents with other physical and emotional conditions, including the nerve disorder Reflex Sympathetic Dystrophy, anxiety, depression, and anger management problems.

In 2001, Doe applied for SSI benefits from the SSA. The psychological evaluation submitted to the SSA showed her Full Scale Intelligence Quotient (IQ) to be sixty-nine, Verbal IQ to be seventy-seven, and Performance IQ to be sixty-five. Using these scores and personal observations of Doe's functional abilities, the doctor examining her concluded "[s]he has multiple physical, mental, and emotional impairments, including cerebral palsy with left spastic hemiparesis and Mild Mental Retardation." The SSA awarded Doe SSI based on a primary diagnosis of mental retardation and a secondary diagnosis of cerebral palsy. That determination has never been challenged. [8] Respondent South Carolina Department of Health and Human Services (HHS) and its agent, DDSN, sought reimbursement from the federal government for services they supplied using the diagnostic code for mental retardation.

Doe is unquestionably disabled. Looking to her IQ scores beginning at age twelve, Doe's full-scale IQ scores ranged from a low of sixty-six to a high of seventy-three.

DDSN approved Doe's application for waiver services in March 2003, and provided her with HCBS. Because Doe's parents were unable to care for her at home, DDSN placed Doe in a Community Training Home II (CTH II) facility operated by the Newberry County Disabilities and Special Needs Board. [9]

In 2005, DDSN re-evaluated and terminated Doe's eligibility for waiver services. Doe contended her benefits should not be terminated and requested a fair hearing to review that decision pursuant to 42 U.S.C. § 1396a(a)(3) (2006) and section 126-380 of the South Carolina Code of Regulations. Relying on DDSN's definition of mental retardation in its policy guidelines that the onset of mental retardation must occur prior to age eighteen, the Hearing Officer referenced "accepted psychological doctrine" and concluded Doe was not mentally retarded. [10] Finding the absence of mental retardation (and related disability) dispositive, the Hearing Officer did not reach the issue of whether Doe met the Level of Care requirements for waiver services eligibility. The ALC affirmed the Hearing Officer. This appeal followed.

III.

STANDARD OF REVIEW

Our standard of review is governed by the Administrative Procedures Act. S.C. Code Ann. § 1-23-380(5) (Supp. 2010). The Court may affirm the agency's decision, remand the matter, or reverse or modify it

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. We reverse because the decisions of the Hearing Officer and ALC are controlled by an error of law.

IV.

LAW/ANALYSIS

A.

It is Doe's position that the SSA determination of disability and receipt of basic Medicaid through SSI is binding on DDSN's determination of whether she is entitled to receive waiver services. In the alternative, Doe argues it was error to impose an age-eighteen-onset requirement in determining whether she is mentally retarded and that DDSN must use the age-twenty-two-onset definition of mental retardation.

We disagree that, in the context of waiver services, DDSN is bound by the SSA's determination that Doe is disabled, for Doe conflates her entitlement to basic Medicaid services by virtue of her SSI disability with the issue of whether she is eligible to receive HCBS through the optional Medicaid waiver program. The federal government has made it manifestly clear that states have wide discretion in designing a waiver program that is tailored to the needs of the particular state. For example, in the "Application for a §1915(c) Home and Community-Based Services Waiver" promulgated by the Centers for Medicare & Medicaid Services, the purpose of the HCBS Waiver Program is as follows:

> The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in § 1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that

families and communities provide.

> The Centers for Medicare & Medicaid Services (CMS) recognize[] that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Therefore, it is clear that states may impose additional criteria to the SSI definition of mental retardation for the purposes of waiver services eligibility, and the SSI's prior determination of Doe as mentally retarded is not binding on the state's waiver services eligibility determination of whether Doe is mentally retarded.

8.

Although we reject Doe's initial argument, we do agree with her contention that it was error to impose an age-eighteen-onset requirement in determining whether she is mentally retarded. South Carolina's waiver application allows it to do one very specific thing: substitute home or community based services (HCBS) for mandatory Medicaid services with respect to a defined subset of categorically needy persons, without providing HCBS to every categorically needy person in the State. 42 C.F.R. § 440.240(b) (2010) ("The [State] plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group: (1) The categorically needy...."); *Id.* § 440.250(k) ("[T]he services provided under [a] waiver [of § 440.240] need not be comparable for all individuals within a group."); *Id.* § 441.301(b)(6) (requiring a waiver request to "[b]e limited to one of the... target groups or any subgroup thereof" and defining the target groups as the aged, disabled, mentally retarded, developmentally disabled, and mentally ill). Thus, the scope of HCBS furnished under the waiver program and recipient eligibility criteria are defined by the waiver application. However, South Carolina's waiver application with the federal government does not include any age-of-onset requirement.

To the extent a state is permitted to issue regulations interpreting the general eligibility requirements included in its waiver application, South Carolina regulations reveal no intent to vary from the requirement that the onset of mental retardation occur prior to age twenty-two. Rather, the only regulation addressing eligibility for HCBS states that HCBS "may be provided to Medicaid eligible persons eighteen years of age or older, who have been determined by community long term care to require a skilled or intermediate level of care." 27 S.C. Code Ann. Regs. 126-304 (1976). No South Carolina regulation imposes additional diagnostic criteria for mental retardation in the context of waiver services.

Moreover, we find DDSN's policy guidelines are not entitled to any deference in this regard. The scope of DDSN's rulemaking authority is defined by the South Carolina General Assembly, and DDSN may exercise such authority only in that manner. As discussed above, in 1990, the General Assembly adopted a definition of mental retardation in line with the SSI definition adopted by the federal government in 1985. Thereafter, DDSN promulgated regulation 88-210(F), which recites the SSI/44-20-30 definition of mental retardation and defines the term "developmental period" as the period from conception to age twenty-two, consistent with the SSI definition. [11] Thus, the informal agency policy issued by DDSN, purporting to implement an age-eighteen-onset requirement should be disregarded in determining what classes of mentally retarded South Carolinians are entitled to Medicaid waiver services because it lacks the force and effect of law and is in direct conflict with Regulation 88-210(F), which defines the developmental period as extending to age twenty-two.

V.

CONCLUSION

In sum, it is clear that South Carolina *could have* listed additional criteria in the waiver application for the purpose of defining the population to whom it would provide waiver services. Likewise, DDSN *could have* promulgated regulations incorporating those additional criteria as part of the definition of mental retardation. But no such steps were taken. Rather, South Carolina adopted a broad definition of mental retardation in section 44-20-30, using language that parallels the SSI definition, and in Regulation 88-210, DDSN interpreted that definition in a manner consistent with the SSA. DDSN's interpretation of section 44-20-30 in its policy guidelines directly conflicts with Regulation 88-210 and should be disregarded.

We find the Hearing Officer and ALC erred in applying an age-eighteen-onset requirement for mental retardation. We reverse and remand for consideration of whether, applying the proper legal standard for mental retardation (onset prior to age twenty-two), Doe is eligible to continue to receive waiver services.

REVERSED AND REMANDED.

TOAL, C.J. and BEATTY, J., concur.

JUSTICE HEARN:

Respectfully, I concur in part and dissent in part. I agree with the majority's holding that South Carolina can impose more restrictive criteria for mental retardation in its waiver application or in a regulation. Where I part company with the majority, however, is with respect to whether Regulation 88-210(F) applies in this case. Because I do not believe it does, I would find this absence of controlling statutory or regulatory criteria permitted DDSN to apply its own diagnostic criteria to Doe and would affirm.

I.

As the majority correctly notes, the starting point for our analysis is the waiver application itself. Although many states elected to supply a wide range of specific diagnostic criteria in their applications, [12] South Carolina has not done so. [13] Similarly, Section 44-20-30(11) of the South Carolina Code (2002) simply defines mental retardation as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." Due to this lack of guidance, in 1998 DDSN itself adopted the criteria from the DSM-IV and the American Association on Mental Retardation, Ninth Edition, defining mental retardation as: (1) an IQ of approximately seventy or below; (2) a score of approximately seventy or below on standardized measures of adaptive behavior; and (3) onset before the age of eighteen. These guidelines have not been promulgated into an official regulation.

Section 88-210(F) of the South Carolina Code of Regulations differs from DDSN's guidelines in that it extends the developmental period to the individual's twenty-second birthday. *See* 26 S.C. Code Ann. Regs. 88-210(F) (2009). The majority accordingly posits that Regulation 88-210(F) conflicts with, and thus trumps, DDSN's guidelines as to the developmental period. However, the regulatory definition of "developmental period" by its terms applies only to the regulations in question, *see id.* § 88-210, which concern the licensing of various facilities by DDSN and not eligibility for waiver services, *see id.* § 88-105. The majority thus states correctly that the scope of this regulation is "the licensing of *all* programs" for the treatment of the mentally retarded, even if those facilities provide waiver services. However, two unitalicized words are of particular import yet side-stepped by the majority: "licensing" and "programs." Just as with

statutes, we apply the plain meaning of regulations "without resort to subtle or forced construction to limit or expand the regulation's operation." *Byerly v. Connor*, 307 S.C. 441, 444, 415 S.E.2d 796, 799 (1992). Because Regulation 88-210(F) plainly applies only to the licensing of programs and not eligibility for services, it has no application in the case before us. As the majority itself recognizes, the *only* regulation concerning eligibility for waiver services provides no guidance as to what constitutes mental retardation. *See* 27 S.C. Code Ann. Regs. 126-304(A) (1976) ("Home and community based services may be provided to Medicaid eligible persons eighteen years of age or older, who have been determined by community long term care to require a skilled or intermediate level of care."). The policy guidelines at issue here clearly are not at odds with this regulation, nor do they conflict with Regulation 88-210(F) as they do not concern the licensing of programs.

In support of its conclusion that the regulation applies, the majority details the history of Regulation 88-210 and section 44-20-30 to conclude that Regulation 88-210(F) actually is an interpretation of section 44-20-30(11). When this regulation was passed, the licensing provisions were contained in Article 3 of Chapter 21, and that chapter and article were (and still are) cited as the sole authority for it. The majority then points out that these provisions were subsequently moved to Article 5 of Chapter 20 at the time the General Assembly added the undefined term "developmental period" to the definition of mental retardation found in the general provisions of Article 1 of Chapter 20. In my opinion, importing the specific licensing definition of developmental period into the general provisions solely based on this renumbering of the statutes lets the tail wag the dog, and I accordingly decline to divine any expansion of the regulation's scope. The majority therefore "resort[s] to subtle ... construction to... expand" the regulation's operation. *See Byerly*, 307 S.C. at 444, 415 S.E.2d at 799. To borrow the majority's words, "[i]n the more than twenty years following these changes [to Title 44], " DDSN has never sought to expand the regulation beyond its plainly stated boundaries.

Even accepting as correct the majority's contention that Regulation 88-210(F) controls, the only criteria provided is that the symptoms of mental retardation must present themselves prior to age twenty-two. The open question therefore is what those symptoms must be in the absence of a comprehensive definition found in the waiver application or a regulation, namely whether the remainder of the diagnostic criteria in the guidelines apply or the SSI definition controls.

By acknowledging DDSN is free to adopt its own criteria which are more restrictive than those found in the SSI definition and narrowing its focus on the conflict between the guidelines and Regulation 88-210(F), the majority ostensibly agrees the guidelines are in effect unless they conflict with state law. However, the majority at times seems to suggest that the SSI definition has been adopted as a matter of state law and therefore is the controlling definition. In particular, the majority consistently references the SSI definition and how it "parallels, " "mirrors, " is "in line with", and is "consistent with" state legislative enactments. Furthermore, the majority writes that Regulation 88-210(F) "recites" the SSI definition of mental retardation and "interpret[s] [section 44-20-30(11)] in a manner consistent with" it. The majority also states that "the scope of HCBS furnished under the waiver program and recipient eligibility criteria are defined by the waiver application, " and this application "reveals no intent to vary from or otherwise limit the group of individuals encompassed by the SSI definition of mental retardation." It accordingly appears the majority holds that state law incorporates the SSI definition. The conclusion which follows is that DDSN's guidelines are invalid *in toto* because they wholly conflict with this definition. To the extent this is the majority's holding, I disagree. [14]

In my opinion, section 44-20-30(11) and Regulation 88-210(F) are not similar to the SSI definition in any substantial regard. The SSI definition for mental retardation is as follows:

> Mental retardation refers to significantly subaverage general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period; i.e., the evidence demonstrates or supports onset of impairment before age 22.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded; or

B. A valid verbal, performance, or full scale IQ of 59 or less; or

C. A valid verbal, performance, or full scale IQ of 60-70 and a physical or other mental impairment imposing an additional and significant work-related limitation or function; or

D. A valid verbal, performance, or full scale IQ of 60-70, resulting in at least two of the following:

1. Marked restriction in activities of daily living; or

2. Marked difficulties in maintaining social function; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration.

20 C.F.R. Pt. 404, Subpt. P, App. 1 § 12.05. Section 44-20-30(11) simply defines mental retardation as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." When these two sections are juxtaposed, it is clear that the *only* mirror image between the two is in the first line of the SSI definition. In my opinion, there is nothing to suggest that the General Assembly implicitly agreed to incorporate the remaining 156 words by using language similar to the first line of the SSI definition of mental retardation.

Like section 44-20-30(11), Regulation 88-210(K) defines mental retardation in broad terms. The only difference is that subsection (F) defines developmental period as being before the individual's twenty-second birthday. While it does provide one more piece of the puzzle and only as to the licensing of programs and not waiver eligibility it conspicuously lacks the myriad other diagnostic criteria present in the SSI definition. I accordingly disagree that section 44-20-30(11) and Regulation 88-210(F) are similar to the SSI definition and would find no intent to adopt the SSI definition of mental retardation as a matter of state law. Because it is not the law of this State, I would stay true to the majority's central premise that states are free to set their own diagnostic criteria and find the SSI definition does not inform our analysis.

Due to the lack of controlling statutory or regulatory guidance, it was incumbent upon DDSN to set its own criteria for mental retardation. I certainly agree that such policy guidance ordinarily does not have the effect of law and can never trump a valid regulation or statute. *See* S.C. Code Ann. § 1-23-10(4) (2005). However, I do not read the majority's opinion as suggesting that such guidance must be wholly disregarded in cases where there are no controlling statutes or regulations. In this case, I do not believe there is any controlling law, and it was therefore necessary for DDSN to issue its own criteria. I would accordingly adhere to our precedents deferring to agency interpretations of statutes and hold the hearing officer did not err in applying DDSN's standard, including onset before age eighteen. *See Byerly Hosp. v. S.C. State Health & Human Servs. Fin. Comm'n*, 319 S.C. 225, 229, 460 S.E.2d 383, 386 (1995) ("[B]ecause the Commission has been designated as the single state agency for implantation of Medicaid, great deference must be

accorded its interpretations of Medicaid laws and regulations.").

II.

Because I believe the hearing officer did not commit an error of law in applying DDSN's definition of mental retardation, I proceed to reach the other issues raised on appeal by Doe.

A. Evidence of Mental Retardation

Turning to facts of this case, Doe's scores place her right on the border of mental retardation under DDSN's definition. Between the ages of twelve and seventeen, her full scale IQ scores ranged from a low of sixty-eight which was felt to be an underestimate of her abilities to a high of seventy-three. Additionally, the only adaptive behavior score obtained before her eighteenth birthday was a seventy. At this point, it is left to the professional judgment of those reviewing Doe's application to determine whether she is mentally retarded under DDSN's standards. While the record contains diagnoses made by various individuals, including physicians who treated Doe, that she was mentally retarded before she turned eighteen, the record also contains testimony of DDSN officials expressing concern about the bald nature of some of these diagnoses and evidence that Doe's levels of functioning may have been higher than meets the eye. Additionally, the record contains findings that she is in the borderline range of intelligence, which is not equivalent to mental retardation. The record contains similarly conflicting evidence of the impact her intellectual deficits have on her adaptive skills.

Viewing the record in its entirety, I cannot say the ALC erred in affirming the hearing officer. I believe there is substantial evidence to support the conclusion that Doe does not suffer from mental retardation. Indeed, there may be substantial evidence to support the opposite conclusion as well. But, the fact that reasonable minds may reach an opposite result based on the same evidence does not render the hearing officer's order invalid. *Waters v. S.C. Land Res. Conservation Comm'n*, 321 S.C. 219, 226, 467 S.E.2d 913, 917 (1996) (stating the fact that one could draw inconsistent conclusions from the same body of evidence does not render the agency's decision unsupported by substantial evidence). The parties here presented voluminous evidence of Doe's condition, each side fleshing out its position amply. In the end, this case boiled down to a quintessential factual determination and battle of the experts. Under our standard of review, I would find no error in the hearing officer's decision. [15]

Doe next argues the hearing officer and the ALC erred in not giving controlling weight to the diagnoses of mental retardation made by her treating physicians. She bases her argument on 20 C.F.R. § 404.1527(d)(2), which provides, "If [the SSA] find[s] that a treating source's opinion on the issue(s) of the nature and severity of [the] impairment (s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] case record, [the SSA] will give it controlling weight." Without discussing whether DDSN had sufficient reason to not give controlling weight to these diagnoses, the language in this regulation by its very terms applies only to SSA determinations of disability. No party here disputes that Doe is disabled. Instead, we are faced with a state agency determination of whether Doe is eligible for ICF/MR waiver services. I can find no statutes or regulations, and Doe has not directed us to any, which require a state agency in DDSN's position to give controlling weight to a treating physician's diagnosis.

This is not to say, however, that a treating physician's diagnosis is not entitled to any weight. To the contrary, DDSN and the hearing officer ought to examine and consider the opinions of those doctors as relevant, probative evidence of an applicant's condition. Under the facts of a particular case, DDSN and the hearing officer may attach any such weight to these diagnoses as they see appropriate and the facts permit. While the policy behind 20 C.F.R. § 404.1527(d)(2) is a good one, there is no similar requirement under our regulations, and this Court is not in a position to

create one. Instead, the diagnoses should be considered along with the whole body of evidence in the record. On appeal, the ALC and the appellate courts also should consider them in light of all the other evidence in determining whether DDSN's decision is supported by substantial evidence, or is arbitrary or capricious. [16]

In a similar vein, Doe also argues the hearing officer restricted the rights of her treating physicians to practice medicine by not giving controlling weight to their diagnoses. Every state seeking to offer waiver services must provide in the application "[a] description of who will make these evaluations and how they will be made." 42 C.F.R. § 441.303(c)(1). South Carolina's approved program specifically permits non-physicians to determine whether an applicant suffers from mental retardation. [17] South Carolina Waiver, App. B-6(c). In this case, DDSN and the hearing officer disagreed with the diagnoses made by Doe's treating physicians. As discussed, while the fact that some doctors did diagnose her as being mentally retarded certainly is relevant evidence, it is just evidence. Simply because DDSN officials and the hearing officer in a regulatory action disagreed with the diagnoses of Doe's treating physicians in no way limits their ability to practice medicine. Not only did these officials have the authority to determine eligibility for MR/RD waiver services, it would be absurd to hold that a disagreement with a physician infringes on that doctor's ability to practice medicine in any way.

Doe finally argues the hearing officer erred in considering evidence outside of the record. In particular, Doe argues the hearing officer concluded the SSA awarded SSI benefits for an unidentified condition other than mental retardation based on his own experiences as an SSA disability examiner and disability hearing officer. However, I believe Doe's argument is not preserved for review as she has raised it for the first time before this Court. Doe accordingly argues that because she is an incompetent, we should relax our preservation rules. *See Galloway v. Galloway*, 249 S.C. 157, 160, 153 S.E.2d 326, 327 (1967). It is within our discretion to relax the preservation requirement when the rights of a minor or incompetent are concerned. *Ex parte Morris*, 367 S.C. 66, 65, 624 S.E.2d 649, 654 (2006). I would decline to do so in this case because Doe was at all times well-represented by counsel. *Cf. Cumbie v. Cumbie*, 245 S.C. 107, 113, 139 S.E.2d 477, 480 (1964) (reaching unpreserved issue because "[i]t is quite apparent here that the guardian ad litem for the incompetent and the minor defendants treated the appointment as a pure formality, and, as far as the record goes, made no effort whatever to protect the interests of either the incompetent or said minors").

B. Related Disability

Doe argues she has two related disabilities, cerebral palsy and epilepsy. At no point did DDSN ever question whether she suffers from either of those conditions. Instead, the relevant discussion was the *extent* of those conditions, including whether they both had the requisite effect on Doe's adaptive skills and, in particular, whether her epilepsy was as severe as she contended it was. While the witnesses in this case did observe and document her seizures, there was no SSA diagnosis of epilepsy as there was for cerebral palsy. [18] Accordingly, she first argues the hearing officer erred in not following the procedures outlined in 42 C.F.R. § 435.541 when evaluating her seizures. *See* 42 C.F.R. § 435.541(c)(4)(i) ("The [state] agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:... The individual applies for Medicaid as a non-cash recipient... and... [a]lleges a disabling condition different from, or in addition to, that considered by SSA in making its determination...."). However, this requirement only applies when a state agency instead of the SSA is making a *disability* determination instead of the SSA, which only occurs in specific situations not applicable here. *See* Medicaid Program; Eligibility Determinations Based on Disability, 54 Fed. Reg. 50, 755 (Dec. 11, 1989). Doe is not asking DDSN to determine whether she is disabled by her epilepsy; she is asking DDSN to determine whether this condition is a related disability for purposes of receiving HCBS. Because these are two different determinations, I do not believe the hearing officer erred in not following 42 C.F.R. § 435.541 with respect to Doe's epilepsy.

She next argues that the hearing officer erred in applying the definition of related disability found in section 44-20-30(15) [19] as opposed to the Medicaid [20] definition. Although I believe the hearing officer did not err in applying the

definition from section 44-20-30(15), any error involved would be harmless. Both definitions contain the same requirement for limitation in three of six major life areas, and as I conclude below, the hearing officer's findings that Doe's conditions are not so limiting is supported by substantial evidence. Doe also argues the hearing officer in any event erred in his application of the definition of related disability found in section 44-20-30(15). I agree with Doe that the hearing officer erred in his interpretation, but I would find this error harmless as well for the same reason.

The record establishes that Doe's adaptive behavior scores were within the range for mental retardation, and therefore within the range for a related disability. Additionally, the evidence shows that her limitations arose prior to her twenty-second birthday and are likely to continue indefinitely. However, I believe there is substantial evidence to support the conclusion that Doe has not met the requirement of experiencing "substantial limitations" in three of the six major life areas listed in the statute.

The hearing officer described her limitations as follows:

> [Doe] walks with a mild limp, with an awkward gait and she has some difficulty with balance secondary to her left hemiparesis. [Doe] has weakness in her left arm with some contracture in her left hand. She can only use her left hand as an assist/stabilizer for small objects and she has difficulty using zippers, and buttoning small buttons. [Doe] is independent with dressing, bathing, toileting, eating, transferring from one surface to another and ambulation; however, she may require some prompting to perform some of these activities at times.

In his final order, the hearing officer made a series of specific findings leading to the conclusion that Doe does not have a substantial limitation in any of the six major life areas listed in the statute. In sum, he found,

> [Doe's] Cerebral Palsy and Epileptic Seizure Disorder do not prevent [Doe] from performing all self-care activities with little or no assistance or supervision. Her Cerebral Palsy and Epileptic Seizure Disorder do not affect her understanding and use of language or learning; however, [Doe's] longstanding mental disorders and learning disorder and/or borderline intellectual function do affect these areas. She is able to be independently mobile despite her physical handicaps. [Doe's] Cerebral Palsy and Epileptic Seizure Disorder do not limit [Doe's] capacity for independent living; however, her longstanding mental disorders are the biggest obstacle to this area of major life activity. [Doe's] Cerebral Palsy and Epileptic Seizure Disorder do not result in substantial functional limitations in self-care, understanding and use of language, learning, mobility, self-direction or capacity for independent living; therefore, she does not have a Related Disability.

As the ALC recognized, Doe has submitted voluminous evidence to support her position that she does indeed suffer from a related disability. Numerous witnesses recounted the limitations Doe's conditions place on her daily life, and no one before the Court contends that Doe can lead a truly normal life. DDSN, on the other hand, introduced equally voluminous evidence to demonstrate that her limitations may not be as severe as they appear and are perhaps the product of her intentional efforts to not integrate herself into the community. In the end, the hearing officer found that any limitations Doe does have generally result from mental illness and disorders, not cerebral palsy and epilepsy. [21] Once again, we are faced with an extremely close factual determination. But, also once again, it is not the province of an appellate court to weigh the evidence before it on appeals from administrative proceedings. Based on our standard of review, I believe there is substantial evidence to support the finding that Doe does not have substantial limitations in any of the major life areas and accordingly does not suffer from a related disability. Additionally, I can discern no evidence that this finding by the hearing officer was arbitrary, capricious, or an abuse of discretion. Rather, it appears to be a well-reasoned decision following a thorough review of the evidence presented.

C. Due Process Claims

Doe finally argues the hearing officer violated her constitutional due process rights in three ways: (1) basing his decision on reasons other than those contained in the notice provided by DDSN to Doe; (2) determining Doe failed to exhaust her administrative remedies; and (3) permitting DDSN to engage in retaliatory conduct. I disagree.

As to her first argument, a state cannot withdraw Medicaid benefits without providing notice and an opportunity to heard. *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 786-87 (1980). In order to meet the requirements of procedural due process, the State must provide adequate notice, adequate opportunity to be heard, the right to introduce evidence, and the right to confront and cross-examine witnesses. *In re Vora*, 354 S.C. 590, 595, 582 S.E.2d 413, 416 (2003).

Initially, I do not believe Doe's notice arguments are preserved for review. Nowhere in the record does it appear she raised this issue to the hearing officer or the ALC. Indeed, Doe concedes as much by preemptively arguing in her initial brief that we should relax our preservation rules because she is an incompetent. As discussed previously, I would decline to do so under the facts of this case. Furthermore, I question the merits of her argument. Doe claims the hearing officer engaged "[i]n a classic case of trial by ambush" when he considered the results of evaluations performed by school psychologists offered by DDSN from her high school years. However, Doe's argument ignores the fact that she had three months from the close of DDSN's case-in-chief to prepare her own case. [22] It would therefore appear she had ample notice and opportunity to respond to this alleged ambush.

Second, Doe contends the ALC erred in finding she has not exhausted her remedies with respect to her argument that DDSN did not provide her with free choice of facilities for treatment. This issue is now moot in light of the decision of the United States Court of Appeals for the Fourth Circuit that her freedom of choice claim fails as a matter of law. *See Doe v. Kidd*, 501 F.3d 348, 358-60 (4th Cir. 2007) (*Doe I*).

Finally, Doe argues the final DDSN evaluation, the one which led to the termination of her benefits, was in retaliation for a separate civil rights lawsuit she filed in federal court. [23] In her brief to this Court, Doe engages in a lengthy discussion of the record but cites no law to support her contentions. She then argues due process entitles her to notice and an opportunity to respond to the final 2005 evaluation, again citing no law and making only passing references to the Fourteenth Amendment and the Medicaid Act. The essence of her arguments, however, is more of an attack on the credibility of DDSN's final decision, not that DDSN engaged in retaliatory conduct. Because I have already resolved that issue, I find no error in rejecting this claim.

III.

The case before us is the culmination of a long and contentious dispute regarding one young woman's eligibility for certain Medicaid benefits. Throughout this process, tensions have flared as the parties have engaged in a vigorous dispute over some very complicated and emotionally-charged issues. At the center of all of this is a now twenty-eight-year-old woman with undeniable cognitive and adaptive deficits. After a review of the regulations concerning the labyrinthine Social Security and Medicaid Acts, I agree there is no rule requiring states to be bound by the federal government's disability determination or the SSI definition of mental retardation. I believe there is an express policy of granting states wide latitude in designing and implementing programs to best meet their needs and the needs of the target population. Where I part company with the majority, however, is with respect to whether South Carolina has adopted a different definition of mental retardation. In my opinion, DDSN acted within its authority in adopting its present definition and would apply it in this case.

As to Doe's remaining arguments, based on our standard of review, I would find the hearing officer's determination that Doe does not suffer from mental retardation or a related disability is supported by substantial evidence. In administrative appeals, this Court does not make findings of fact or weigh evidence; we sit only to ensure that the findings below are supported by substantial evidence and are not arbitrary, capricious, or an abuse of discretion. As discussed, both parties presented copious evidence of the nature and extent of Doe's conditions. Accordingly, it was the job of the hearing officer to make this incredibly close factual call. Simply because reasonable minds may disagree with the result does not make it unsupported by substantial evidence or arbitrary or capricious. I also believe the hearing officer did not commit any errors of law. Therefore, I would affirm the order of the ALC.

PLEICONES, J., concurs.

Notes:

[1] Final Administrative Order, June 5, 2006.

[2] A showing that the average annual cost of HCBS would not exceed that of institutional services is also required. 42 U.S.C. § 1396n(c)(2)(D) (2006).

[3] Although this particular part of the regulations concerns benefits under a different portion of the Social Security Act, this listing of impairments is the operative listing for Supplemental Security Income and Medicaid purposes. 20 C.F.R. § 416.905 (2011).

[4] South Carolina filed a Request for a Renewal to a § 1915(c) Home and Community-Based Services Waiver (Effective January 1, 2010) and a Request for an Amendment to a § 1915(c) Home and Community-Based Waiver (Effective March 1, 2011). However, neither the renewal or amendment waiver application altered the Level of Care evaluation criteria or frequency.

[5] Prior to the 1990 Act, South Carolina defined a "mentally retarded person" as "any person, other than a mentally ill person primarily in need of mental health services, whose intellectual deficit and adaptive level of behavior require for his benefit, or that of the public, special training, education, supervision, treatment, care or control in his home or community, or in a service facility or program under the control and management of the Department." S.C. Code Ann. § 44-21-30 (1976).

Subsequent to the briefing and arguments in this case, the General Assembly, in 2011 Act No. 47, changed the references to mental retardation in section 44-20-30 to "intellectual disability." Although the definition of intellectual disability is the same as it was for mental retardation, it has been moved to subsection 12 of section 44-20-30. To ensure our references are consistent with the record in this case, we will continue to use the terminology in effect at the time this case arose and was argued.

[6] Chapter 88 of the South Carolina Code of Regulations draws its statutory authority from title 44, chapter 20 of the South Carolina Code. While chapter 88 continues to list its statutory authority as article 3 of chapter 21, title 44 of the 1976 Code, that article was repealed in 1990. The relevant statutory provisions were reenacted as article 5 of chapter 20. This change was part of the same act that adopted the new definition in section 44-20-30. 1990 S.C. Acts 2184, 2200-04. Notably, while the pre-1990 definition of mental retardation applied only to the article of title 44 in which it was located, the new definition in section 44-20-30 explicitly applied to the entire chapter. Thus, the General Assembly manifested its intent that the definition in section 44-20-30 would apply to the licensing provisions interpreted in chapter 88 of the South Carolina Code of Regulations. Those regulations dictate that the developmental period extends to age twenty-two. In the more than twenty years following these changes in the law, DDSN has not altered the regulations to reflect a contrary view.

[7] In ignoring Regulation 88-210 and finding DDSN's policy guidelines properly supplied more specific criteria outside the waiver application, the dissent acknowledges the fact that DDSN's policy guidelines are not regulations promulgated by a state agency; yet the dissent finds the policy guidelines are entitled to deference in interpreting section 44-20-30. 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). 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. Indeed, the only South Carolina law addressing the age onset requirement is Regulation 88-210.

[8] In other litigation involving Doe, the United States Court of Appeals for the Fourth Circuit noted that Doe "has developmental disabilities including epilepsy, mild mental retardation, and cerebral palsy." *Doe v. Kidd*, 501 F.3d 348, 351 (4th Cir. 2007).

[9] A CTH II is not an ICF/MR facility; it is classified as respite care rather than institutional care. Patients in a CTH II receive twenty-four hour supervision and some training depending on their assessed needs and care. A CTH II facility has one to two staff responsible for up to four individuals. During the pendency of this appeal, DDSN agreed to continue providing Doe HCBS benefits.

[10] The hearing officer further determined that Doe did not meet the definition of a related disability. Because we conclude the hearing officer applied the incorrect definition of mental retardation, we need not reach Doe's separate challenge to the related disability finding.

[11] The dissent asserts that Regulation 88-210 is inapplicable to the question before us because it refers only to licensing, not eligibility. This ignores the fact that Regulation 88-210 is an interpretation of the same statute, section 44-20-30, purportedly interpreted by DDSN's policy guidelines. We adhere to the basic principle that the same word should not be given disparate meanings within a single statutory scheme. Further, the plain language of the regulation shows that the definitions in 88-210 apply to the licensing of *all* programs "for the care, maintenance, education, training or treatment" of mentally retarded persons that operate for at least ten hours per week, unless specifically excluded. 26 S.C. Code Ann. Regs. 88-105. Nothing in the text of 88-105 or 88-210 excludes non-residential waiver services from the scope of the definitions found therein, and the dissent does not appear to contest that some of the programs subject to the definitions in 88-210 are waiver services. Therefore, in our view, Regulation 88-210 expresses the view that the term "developmental period" in section 44-20-30 has the same meaning in the context of waiver services as it does in the context of basic Medicaid services.

[12] For example, Mississippi's application defines mental retardation as an IQ score of approximately seventy or below, age of onset prior to age eighteen, and a determination of deficits in adaptive behavior. Application for 1915(c) HCBS Waiver, Mississippi, App. B-6(d). Alaska defines the condition as an IQ of less than seventy, plus or minus five points; age of onset prior to age twenty-two; and "a substantial disability to the individual's ability to function in society." Application for 1915(c) HCBS Waiver, Alaska, App. B-6(d). Iowa simply incorporates by reference the definition of mental retardation found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV). Application for 1915(c) HCBS Waiver, Iowa, App. B-1(b).

[13] South Carolina is not alone. Massachusetts' application, for example, merely defines the target group as "[p]articipants age 18 and older with an intellectual disability as defined by the Massachusetts DDS who meet the ICF-MR level of care and who are determined through an assessment process to require Community Living Supports due to a moderate level of assessed need." Application for 1915(c) HCBS Waiver, Massachusetts, App. B-1(b). Virginia's application does the same thing: "Waiver services are limited to the following groups: Individuals of any age with a diagnosis of Intellectual disability/mental retardation:..." Application for 1915(c) HCBS Waiver, Virginia, App. B-1(b).

[14] If the majority is not holding that the SSI definition applies, I do not understand the relevance of the many comparisons between this definition and section 44-20-30(11), Regulation 88-210(F), and the waiver application.

[15] At various points, Doe also argues that DDSN and HHS should be estopped from denying she suffers from mental retardation because they sought reimbursement from the federal government for services they supplied using the diagnostic code for mental retardation. However, it appears Doe did not learn of this fact until discovery. To the extent such an act could give rise to estoppel against the government, Doe's argument must fail because she cannot prove any reliance on this billing practice. *See Grant v. City of Folly Beach*, 346 S.C. 74, 80, 551 S.E.2d 229, 232 (2001).

[16] For example, if a treating physician's diagnosis has not been called into question or there are no competing diagnoses, not giving it controlling weight may be arbitrary and an abuse of discretion. That situation is not present in the case before us.

[17] The waiver application in effect at the time permitted physicians to make an eligibility determination. Based on this, Doe argues that because her treating physicians found her to be mentally retarded, their diagnoses control. However, this argument assumes that her treating physicians were actually "performing initial evaluations of level of care for waiver participants." Nothing in the record indicates that they were performing such a function here.

[18] The doctor performing the SSI examination concluded "[s]he has multiple physical, mental, and emotional impairments; including cerebral palsy with left spastic hemiparesis and Mild Mental Retardation." Based on this assessment, which included a fairly thorough review of Doe's condition, the SSA awarded her SSI with a primary diagnosis of mental retardation and a secondary diagnosis of cerebral palsy.

[19] Section 44-20-30(15) provides,

> "Related disability" is a severe, chronic condition found to be closely related to mental retardation or to require treatment similar to that required for persons with mental retardation and must meet the following conditions:
>
> (a) It is attributable to cerebral palsy, epilepsy, autism, or any other condition other than mental illness found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to those required for these persons.
>
> (b) It is manifested before twenty-two years of age.
>
> (c) It is likely to continue indefinitely.
>
> (d) It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

DDSN has offered no additional guidance with respect to related disabilities.

[20] The regulatory definition reads in part,

> Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:
>
> (a) It is attributable to--
>
> (1)Cerebral palsy or epilepsy; or

(2)Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services to those required for these persons.

42 C.F.R. § 435.1010.

[21] Doe again argues the hearing officer failed in not giving controlling weight to the conclusions of the physicians who treated Doe's seizures and cerebral palsy. As I concluded *supra*, failure to do so is not legal error.

[22] Although Doe was the party who brought the case before the hearing officer, DDSN presented its evidence first January 24-26, 2006, and Doe presented her case April 27-28, 2006.

[23] Doe filed a lawsuit alleging violations of the Medicaid Act, Americans with Disabilities Act, and various state laws against DDSN, HHS, and certain state officials. *Doe I*, 501 F.3d at 352. *Doe I* disposed of Doe's claim regarding her freedom of choice of providers. *Id.* at 358-60. The Fourth Circuit subsequently disposed of her remaining argument that DDSN violated her civil rights by not providing her residential services with reasonable promptness. *Doe v. Kidd*, No. 10-1191, 2011 WL 1058642, at *4-5 (4th Cir. Mar. 24, 2011) (*Doe II*). *Doe II* has no impact on our decision in this case as the Fourth Circuit specifically left open the issues regarding Doe's eligibility and retaliation claims for us to consider. *Id.* at *8.

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Q & A
Significant ADA Case: *Crabtree v. Goetz* (M.D. Tenn.)

Produced by Sarah Somers
National Health Law Program
with a grant from the Training and Advocacy Support Center (TASC)[1]

May 2009

Q. I have heard that Medicaid beneficiaries have been successful in challenging cuts to home health and nursing services in Tennessee. What is this case and what is the current status?

A. The case is *Crabtree v. Goetz*, No. 3:08-0930 (M.D. Tenn.) Judge William J. Haynes has granted preliminary injunctive relief to a number of individuals to prohibit the state Medicaid agency from reducing their home health and nursing services. The court held that the plaintiffs had shown that they were likely to be forced into nursing homes or suffer other serious harm if the reductions were not enjoined. The parties have now filed cross motions for summary judgment and briefing is ongoing.

Discussion

The *Crabtree* plaintiffs are individuals with serious disabilities who need extensive care and assistance. They filed suit against Tennessee state Medicaid officials, alleging that they were violating Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act (Section 504) because they (1) failed to provide services in the most integrated setting appropriate; and (2) employed methods of administration that result in discrimination on the basis of disability.[2]

Tennessee's Medicaid program is called TennCare. Program beneficiaries are enrolled in Managed Care Organizations (MCOs), which the state pays to manage care and assure proper utilization of services. Until September 2008, beneficiaries were eligible to receive 24 hours per day, seven days per week of home health and nursing services, if those services were found medically necessary. Home health services are provided by Certified Nursing Assistants (CNAs), and home nursing services are provided by Licensed Practical Nurses (LPNs) or Registered Nurses (RNs).

Effective July 1, 2008, Tennessee enacted the Long-Term Care Community Choices Act of 2008, which provides:

> Sec. 3 ... (c) The long-term care system shall promote independence, choice, dignity, and quality of life...and shall include consumer-directed options that offer more choices regarding the kinds of long-term care services people need....
>
> (e) The long-term care system...shall offer services...delaying or preventing the need for more expensive, institutional care....
>
> Sec. 8(a) The commissioner shall develop level of care criteria for new nursing facility admissions which ensure that the most intensive level of long-term care services is provided to persons with the highest level of need.
>
> Sec.9(a) The commissioner shall develop and implement strategies to encourage the utilization of cost-effective home and community-based services in lieu of institutional placement.
>
> Sec. 15(a) The commissioner shall, upon approval of a waiver amendment granting authority from the federal government, develop and make available consumer-directed options for persons receiving home and community-based long-term care services under the long-term care program, which may include, but are not limited to, the ability to select, direct, and/or employ persons...personal care assistant/attendant...the ability to direct and supervise a paid personal aide in the performance of a health care task....

Long-Term Care Community Choices Act of 2008, Pub. Chap. No. 1180, Senate Bill No. 4181, An Act to amend Tenn. Code annotated, Title 63 and Title 68 and 71.

In August 2008, TennCare began sending notices to individuals over age 21 who were receiving home health aide or nursing care, informing them that these services would be capped at no more than eight hours per day and private duty nursing at no more than 27 hours per week. For those needing a combination of both types of care, no more than 35 hours per week would be covered. There were exceptions for those dependent on ventilators or who had tracheotomies. For most individuals, however, this policy change would dramatically reduce their services.

Tennessee state officials claimed that this reduction was necessary to

[1] Produced by the National Health Law Program with a grant from the Training Advocacy Support Center (TASC), which is sponsored by the Administration on Developmental Disabilities, the Center for Mental Health Services, the Rehabilitation Services Administration, the Social Security Administration, and the HealthResources Services Administration. TASC is a division of the National Disabilities Rights Network (NDRN).

[2] Counsel for Plaintiffs are Stephen F. Gold, the Legal Aid Society of Tennessee, Sherrard & Roe of Nashville, and NHeLP.

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save money because of a financial crisis. They claimed that it would not be possible to implement the LTCCCA and expand the home and community based waiver program unless the cuts were implemented. Also, they claimed that there was significant overprescription of home health and nursing hours and that many individuals actually had family members and friends who could provide the care, rather than having Medicaid cover it. Finally, they alleged that nearly $50 million in savings was required to implement the LTCCCA and make other necessary changes to the long term care system.

Around the time that the notices were sent out, TennCare MCOs began instructing participating health care providers to revise patients' order to reduce services to the limits set forth in the notice, or the patients with new orders would receive not care at all. Some providers complied, others refused.

The case was filed on behalf of individual plaintiffs ranging in age from 21 to 97.[3] They have a variety of chronic and disabling conditions, including cerebral palsy, muscular dystrophy, traumatic brain injury, Parkinson's disease, stroke, and Alzheimer's disease. They cannot afford to pay for in-home nursing out of pocket. Their family and friends already provide as much care as possible. If the cuts were allowed to go into effect, Plaintiffs will be forced either to leave their homes and spouses, children, siblings and parents and go live in a nursing home, or stay home with grossly inadequate care that will damage their health and endanger their lives. For example:

- Sara Crabtree is 28 and lives with her parents and her three children in Gibson. A car accident two years ago left her with a severe brain injury, a severe seizure disorder and incontinency. She needs substantial care, part of which is provided by her parents, who also care for her children. Ms. Crabtree was institutionalized in a nursing home immediately after her accident. She developed a blood clot and almost died, due in part to lack of care. If her home health nursing care were reduced, she would have to go back to a nursing home.

- Plaintiff Harold Lee ("Lee") Murphey, age 30, has Duchene's Muscular Dystrophy, a heart condition, chronic lung disorder, and spinal fusion to immobilize his vertebrae and reduce abnormal motions. Mr. Murphey eats very little by mouth and cannot chew or swallow, cannot reposition his hands or legs, and needs to receive chest percussions to keep his passages clear. He cannot lift his hand to push a call button. He cannot be left alone for five minutes. He lives with his mother, who works to pay the mortgage and put food on the table. Mr. Murphey recently graduated from Middle Tennessee State University with a degree in journalism. His mother cannot provide all of the additional care both because she works and because she cannot lift him and position him by herself. When she is the only one with Mr. Murphey, she cannot even take a shower as she cannot be away from him that long. There is no nursing home in his community or area that can accommodate his needs.

- Plaintiff Betty Jean Taylor is a 69-year-old resident of Mt. Juliet. She has advanced Charcot Marie Tooth disease, a severe neuromuscular disease that destroys both nerves and muscles. She cannot walk or stand. She uses a ventilator, has a functioning tracheotomy, and otherwise uses an oxygen machine. She must be put on and taken off the ventilator, and she requires regular suctioning. If her nursing services are reduced, Ms. Taylor will not be able to live in her home. Her only local family is a son, who also suffers from Charcot Marie Tooth disease and cannot care for her because he struggles to care for himself. Her physicians have stated that nursing home placement would be physically dangerous for Ms. Taylor and that it would also take a psychological toll on her.

- Lorinda Mabry, a 42 year old woman with cerebral palsy, lives alone in an apartment in Antioch. She has severe physical limitations and great difficulty communicating. She needs assistance with eating, drinking, bathing, getting in and out of bed. Even so, she is an activist for people with disabilities who has advocated before the media, elected officials and in the community. She relies on Medicaid-covered in-home nursing services for assistance, because her aging mother can no longer take care of her needs. Her doctor has stated that Ms. Mabry would need to be institutionalized if her in-home nursing hours were reduced to the levels mandated by Defendants.

According to data reported to the federal government in 2006, the last year for which data was available, Tennessee spent 98 percent of its Medicaid long-term care dollars on institutional care and less than 2 percent on home and community-based services. Moreover, the federal government ranks states based on the ratio of spending on institutional versus community-based long term care services: the higher the proportion of spending on institutional services, the lower the ranking. For the past several years, Tennessee was ranked last in the country.

The Court heard Plaintiffs' Motion for Preliminary Injunction on November 7, 2008, nearly two months after the motion was filed.[4] Four plaintiffs, several

[3] Counsel decided not to file the case as a class action, in part because one of the lead counsel in the case is a legal services organization that is barred from participating in class action cases. Instead, the case was filed on behalf of 22 individuals. Since then, an additional 35 plaintiffs have been successfully intervened.

[4] The delay occurred for an unusual reason: four judges recused themselves from hearing the case. The first judge, Aleta Trauger, most likely recused herself because she is close friends with Tennessee's governor, Phil Bredesen. The second judge, Todd J. Campbell, stated that he had "a conflict of interest regarding defense counsel who is on my conflict list." The next judge, Robert L. Echols, simply issued an order stating that he "could not undertake the case at

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caregivers and providers; and three TennCare officials testified at the hearing. On December 19, 2008, the court granted the preliminary injunction.[5]

The reasoning of the opinion hews closely to that of the leading U.S. Supreme Court case, *L.C. v. Olmstead*. The court held that Plaintiffs had demonstrated irreparable injury based on the showing that the cuts would force them into nursing homes and that "such institutionalization would cause [them] to suffer injury to their mental and physical health, including a shortened life and even death for some Plaintiffs."[6] Further, the Court held that success on the merits is likely. The court noted that Defendants had previously determined that community placement was medically necessary – the only justification for cutting services was fiscal. The Court recognized that "[u]nder the ADA,' the opinion of a responsible treating physician in determined the appropriate conditions of treatment ought to be given the greatest of deference."[7] Also significant was the fact that Defendants had made no individualized assessment of the Plaintiffs' needs before making the cuts.

The Court rejected Defendants' contention that continuing to provide services to Plaintiffs in the community would be a fundamental alteration to the TennCare program. It reasoned that the cost of continuing home health and nursing care for the 22 plaintiffs would "be only a fraction of the $50 million that Defendants identify as necessary for the changes Tennessee proposes." However, the Court also noted that it needed to consider the cost of providing benefits to "substantially similar" beneficiaries.[8] However, the court also noted that "states would sometimes be required to make short-term financial outlays, even in the face of mounting fiscal problems."[9]

Defendants had argued that the requested relief would be a fundamental alteration because it would interfere with Defendants' comprehensive plan to move eligible patients into community care settings.[10] The Court held that the LTCCCA was the state's comprehensive plan; however, it noted that Defendants had conceded that it was not yet operational and that "the phasing in of . . .

this time." Subsequently, Senior Judge John T. Nixon recused himself without explanation. Judge Nixon had, however, presided over other litigation against TennCare and clashed repeatedly with the state's attorneys, eventually recusing himself in *John B. v. Goetz*, 3:98-0168 (M.D. Tenn.). Thus, it is possible that he simply did not want to invite additional complications into the case, or just did not want the headache. Finally, Judge Haynes was assigned the case and the litigation continues under him. Fortunately, Defendants had agreed to postpone reduction of the services, pending the preliminary injunction hearing, so this delay didn't harm them.

[5] *See Grabtree v. Goetz*, No. 3:08-0939, 2008 WL 5330506 (M.D. Tenn. Dec. 19, 2009).

[6] 2008 WL 5330506, *30.

[7] *Id.*, *25, quoting *L.C. v. Olmstead*, 527 U.S. __, 610 (1999) (Kennedy, J., concurring).

[8] *Id.*, *27.

[9] *Id.*, *26.

[10] *Olmstead* had suggested that the disruption of such a plan would be a fundamental alteration. *See* 527 U.S. at 605-06.

waiver slots and effective home and community based alternatives . . . are all promissory." Nor was there any evidence of the draft plan called for by the LTCCCA.[11]

Notably, the Court cited two Ninth Circuit decisions that held in favor of the state Defendants in support of its conclusion that Tennessee has no effectively working plan. These decisions have been troublesome for ADA plaintiffs, thus it is encouraging to see that they need not be insurmountable obstacles. The Court noted that:

> In *Sanchez v. Johnson* . . . the Ninth Circuit found an effectively working plan where: (1) a 30 year old state law required coverage of services for people with developmental disabilities to prevent or minimize institutionalization; (2) a significant decrease in institutionalized individuals occurred over a decade; (3) the State significantly increased community based spending, home and community based waiver slots over the course of a decade; (4) the State had a system of individualized community placement plans with extensive databases containing disabled citizens in the system. In *Arc of Washington v. Braddock* . . . the HCB waiver program had increased more that 800 percent and the State doubled the budget for community-based programs, and had a 20 percent reduction in its institutionalized population.[12]

In contrast, the Court held that Tennessee had nothing comparable in effect.

> The Court ordered that the Defendants:[13]
>
> (1) . . . refrain from imposing the cuts . . . upon the Plaintiffs until the community-based, patient centered system authorized by the States [LTCCCA] is implemented and available to Plaintiffs.
>
> (2) . . . conduct individualized assessments of the Plaintiffs to determine the specific needs of each Plaintiff, including the amount of time required to meet those needs, and the extent to which family or other natural supports are available, and whether the needs could be satisfied in the community at less cost than Defendants are presently paying; and
>
> (3) . . . determine whether nursing homes will in fact provide the services each Plaintiff requires.[14]

[11] *Id.*, *29.

[12] *Id.*, *citing Arc*, 427 F.3d 615, 621 (9th Cir. 2005); *Sanchez*, 416 F.3d 1051, 1064 (9th Cir. 2005).

[13] Order, 1 (Dec. 19, 2009). This section of the order is not included in the Westlaw version of the case. For a copy, contact NHeLP.

[14] It is important to emphasize that the Court did not suggest that, if a nursing home were available for a particular plaintiff, that individual would be required to accept such a

The Defendants did not appeal the decision.

Since the injunction was entered, four interyener complaints and additional preliminary injunction motions have been filed on behalf of a total of 35 Plaintiffs. For those Plaintiffs for whom services had not yet been reduced, Defendants agreed to maintain their services pending the litigation. Unfortunately, however, some of the Plaintiffs' services had already been cut, and they were struggling. Defendants would not agree to restore their services. Accordingly, on April 20, 2009, a motion for temporary restraining order and preliminary injunction was filed on behalf of three Plaintiffs asking that their services be restored to the level preceding the cuts.

These Plaintiffs' facts included the following:

- Plaintiff-Intervener Darrell Johnson has only spastic muscle movements and requires a feeding tube and an external catheter. He does not communicate verbally and communicates with family by non-verbal cues. He was receiving 24 hours per day, 7 days per week of home nursing services. In December 2008, his home nursing services were reduced 30 hours per week and home health aide services to 10 hours per week. His wife has been struggling to care for him, despite her own physical limitations which include back problems related to lifting him. Over the past several weeks, Mr. Johnson's physical condition has gotten much worse. He has been coughing violently and is possibly having seizures. His wife has been trying to keep him from falling out of bed or hitting his head by lying on top of him. She fears that she will not be able to prevent harm to him. In addition, her back problems have worsened.

- Plaintiff Bonnie Smiley is paralyzed as a result of a spinal cord injury. She is in constant pain and requires frequent catheterization. She was receiving 24/7 home health services until September 15, 2008, when they were reduced to 35 hours per week. A friend was staying with her to provide additional care, but has since moved away.

- Rachel and Rebecca Bostic were each receiving 12 hours per day of home health aide services (two home health aides for 12 hours per day, seven days a week) until January 24, 2009, when services were reduced to five hours per day (one home health aide for 10 hours a day, seven days a week). Their health has been declining over the past several weeks. They are not getting out of bed as often and Rebecca is having much more frequent aspirations. More importantly, the stress and strain on Mrs. Bostic is taking its toll. She is 65 and she is getting weaker and more exhausted. There is a great risk that Rachel or Rebecca might be harmed and/or forced into a nursing home because Mrs. Bostic is overwhelmed and exhausted.

placement. Rather, it appears to reflect the Court's acceptance of the evidence that Plaintiffs had shown that Defendants did not identify nursing homes that would take plaintiffs because of their serious disabilities.

At a hearing on May 4, the Court granted the temporary restraining order and preliminary injunction for these Plaintiffs, holding that irreparable harm had clearly been established "by reason of threats to their mental and medical conditions." Further, there was a "serious risk" of institutionalization. The Court also held that "the defendants continue to engage in a categorical approach in this matter in a manner that the Court believes deprives these intervener plaintiffs who have disabilities, resulting in a loss of their individual lives, community activities, [and] separate from their loved ones."[15] Finally, the Court held that the relief would not pose an adverse effect on others.[16] The Defendants have not, as of this writing, appealed the order.

The parties have also filed cross-motions for summary judgment on behalf of one Plaintiffs, David Scott, in order to obtain final judgment on some of the legal issues in the case. In addition to challenging the across-the-board cuts, Mr. Scott has also challenged another aspect of the TennCare program. Tennessee law currently defines medical necessity in a very narrow manner. Among other things, in order for a treatment to be found "medically necessary," it must the "least costly alternative . . . adequate to meet an individuals' needs."[17] Under this definition, the MCOs had been reducing home health and nursing services to a level that cost no more than the nursing home care. Because Defendants had calculated that nursing home care cost about $4,200 per month, home health or nursing services that cost more than that amount were not "medically necessary." And, $4,200 worth of home health or nursing services - about the same number of hours that were allowed under the caps.

Mr. Scott's hours had been reduced pursuant to the "medical necessity" definition. Because this criteria is similarly unrelated to individual needs and would also result in institutionalization, he also challenges them under the ADA and Section 504. This question will eventually become relevant for all of the Plaintiffs, as TennCare has announced its intention to apply this "least costly alternative" criteria to all home health and nursing beneficiaries.

Summary judgment briefing will continue through the summer.

[15] Hearing Transcript, at 122. There is no written order. A electronic copy of the transcript can be obtained from NHeLP.

[16] *Id.*

[17] Tenn. Comp. R. & Regs. § 1200-13-15-.05.

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Lessons

The success of this case to date is due to several factors. Undoubtedly, however, the participation of Plaintiffs with extremely sympathetic facts has been pivotal. Moreover, several of the Plaintiffs who were physically and logistically able to do so appeared at the hearing to testify. It seems that the judge was very impressed by their testimony.

It was possible to find such good plaintiffs because of the participation of local attorneys, not all of whom were counsel in the case. Because of a long history of advocacy on behalf of Medicaid beneficiaries with disabilities, many channels of communication to Medicaid beneficiaries and providers had been established over the years. This made locating compelling plaintiffs much easier.

In addition, there was existing publicly-available CMS data showing that Tennessee had a relatively poor record of providing home and community based care. These figures indicated that little or no progress had been made since *Olmstead* was decided in 1999. In both preliminary injunction orders, the judge specifically recognized this fact. For more information about how to locate this data for your state, contact NHeLP or Steve Gold.

Finally, counsel had many avenues for gathering information about Tennessee's budget, which enabled them to present evidence that the fiscal situation was not nearly as dire as the state asserted.

Conclusion

NHeLP will keep advocates informed about further progress and developments in this case.

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Meter v. Harvey, 1:09-cv-00633-JAW (MEDC)

JACOB VAN METER, et al., Plaintiffs,

v.

BRENDA HARVEY, COMMISSIONER, MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendant.

No. 1:09-cv-00633-JAW

United States District Court, District of Maine

January 31, 2011

Plaintiff JACOB VAN METER represented by JACK B. COMART MAINE EQUAL JUSTICE PARTNERS ATTORNEY TO BE NOTICED, JEFFREY NEIL YOUNG MCTEAGUE, HIGBEE, CASE, COHEN, WHITNEY & TOKER, ATTORNEY TO BE NOTICED, MARTHA JANE PERKINS NATIONAL HEALTH LAW PROGRAM ATTORNEY TO BE NOTICED, PETER M. RICE DISABILITY RIGHTS CENTER OF MAINE ATTORNEY TO BE NOTICED, SEAN P. OCIEPKA DISABILITY RIGHTS CENTER OF MAINE ATTORNEY TO BE NOTICED, STACI K. CONVERSE DISABILITY RIGHTS CENTER OF MAINE ATTORNEY TO BE NOTICED.

Plaintiff GAIL FLETCHER Guardian of Adam Fletcher represented by JACK B. COMART ATTORNEY TO BE NOTICED, JEFFREY NEIL YOUNG ATTORNEY TO BE NOTICED, MARTHA JANE PERKINS ATTORNEY TO BE NOTICED, PETER M. RICE ATTORNEY TO BE NOTICED, SEAN P. OCIEPKA ATTORNEY TO BE NOTICED, STACI K. CONVERSE ATTORNEY TO BE NOTICED.

Plaintiff ERIC REEVES represented by JACK B. COMART (See above for address) ATTORNEY TO BE NOTICED, JEFFREY NEIL YOUNG (See above for address) ATTORNEY TO BE NOTICED, MARTHA JANE PERKINS (See above for address) ATTORNEY TO BE NOTICED, PETER M. RICE (See above for address) ATTORNEY TO BE NOTICED, SEAN P. OCIEPKA (See above for address) ATTORNEY TO BE NOTICED, STACI K. CONVERSE (See above for address) ATTORNEY TO BE NOTICED.

Defendant MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES COMMISSIONER represented by JAMES E. FORTIN OFFICE OF THE ATTORNEY GENERAL HEALTH AND HUMAN SERVICES DIVISION LEAD ATTORNEY ATTORNEY TO BE NOTICED, JANINE A. RAQUET MAINE ATTORNEY GENERAL'S OFFICE ATTORNEY TO BE NOTICED

ON PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

JOHN A. WOODCOCK, JR., CHIEF UNITED STATES DISTRICT JUDGE.

Seeking declaratory and injunctive relief from the Maine Department of Health and Human Services (DHHS), Plaintiffs move for class certification. Because Plaintiffs have established each of the requirements for class certification, the Court grants their motion.

I. STATEMENT OF FACTS

On December 18, 2009, Jacob Van Meter, Adam Fletcher-by and through his guardian, Gail Fletcher-and Eric Reeves (Named Plaintiffs) filed a complaint seeking relief under 42 U.S.C. § 1983 for DHHS's alleged violations of the Nursing Home Reform Amendments to the federal Medicaid Act (NHRA), 42 U.S.C. § 1396r(e); Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12131 *et seq.*; and Section 504 of the Rehabilitation Act (Section 504), 29 U.S.C. § 794, for failing to ensure the Named Plaintiffs "receive appropriate treatment in the most integrated setting possible." *Compl.* ¶¶ 1-6 (Docket # 1) (*Initial Compl.*). That same day, the Named Plaintiffs moved individually for leave to proceed *in forma pauperis*. *Application to Proceed in District Court Without Prepaying Fees or Costs* (Docket #s 3, 4, 5). The Magistrate Judge granted those motions on December 21, 2009. *Order Granting Mots. to Proceed* In Forma Pauperis (Docket # 7). On February 22, 2010, DHHS answered the complaint. *Answer to Compl.* (Docket # 12) (*Answer*).

On August 10, 2010, the Plaintiffs moved for leave to file an amended complaint and for class certification. *Pls.' Assented to Mot. for Leave to File First Am. Compl.* (Docket # 22); *Pls.' Mot for Class Certification* (Docket # 23) (*Pls.' Mot.*). The next day, the Court granted without objection the motion for leave to file an amended complaint. *Order* (Docket # 29). That same day, the Plaintiffs filed an amended complaint, which defined the class as:

> [T]he Named Plaintiffs . . . and all other Maine residents who currently are or in the future will be: (1) eligible for and enrolled in MaineCare, (2) age 21 or older, (3) have a related condition as defined at 42 C.F.R. § 435.1010, other than autism, and who do not have a diagnosis of Alzheimer's or dementia, [1] and (4) who are or should be screened for admission to nursing facilities pursuant 42. U.S.C. § 1396r(e)(7) and 42 C.F.R. §§ 483.112 *et seq.*[2]

First Am. Class Action Compl. (Docket # 24) (*Class Action Compl.*). On August 31, 2010, DHHS responded in opposition to the motion for class certification. *Def.'s Opp'n to Mot. for Class Certification* (Docket # 33) (*Def.'s Opp'n*). On September 14, 2010, Plaintiffs replied to DHHS's response. *Pls.' Reply to Def.'s Opp'n to Mot. for Class Certification* (Docket # 40) (*Pls.' Reply*).

II. DISCUSSION

A. The Parties' Positions

1. Plaintiffs' Motion

Plaintiffs argue that class certification is appropriate because all of the elements of a Rule 23(a) and one of the elements of Rule 23(b) are met. *Pls.' Mot.* at 3-4 (citing Fed.R.Civ.P. 23)). They assert that the elements of numerosity, commonality, typicality, and adequacy of representation are met under 23(a). *Id.* at 3. In regards to 23(b), they assert that class action is appropriate under 23(b)(2) because DHHS "has acted or refused to act on grounds generally applicable to the class thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole." *Id.* at 4. They address each element individually.

Plaintiffs observe that the first pre-requisite for class certification is that "the class is so numerous that joinder of all members is impracticable." *Id.* (citing Fed.R.Civ.P. 23(a)(1)). They argue that in the First Circuit, "[n]o minimum number of plaintiffs is required to maintain a suit as a class action, but generally if the named plaintiff demonstrates that the potential number of plaintiffs exceeds 40, the first prong of Rule 23(a) has been met." *Id.* (quoting *Garcia-Rubiera v. Calderon*, 570 F.3d 443, 460 (1st Cir. 2009)). They contend that their putative class consists of at least forty-one current

members with cerebral palsy, an unidentified number of individuals with epilepsy and other related conditions, and "new individuals entering nursing facilities each day who are at risk of the same rights violations and are members of the proposed class." *See Id*. at 3. Plaintiffs also argue that where, as here, only declaratory and injunctive relief is sought, they "need not establish the precise number or identity of class members." *Id.* at 5 (quoting *Rolland v. Cellucci*, No CIV A 98-30208-KPN, 1998 WL 34815562, at *3 (D. Mass. Feb. 2, 1999)).

Having asserted that they meet the First Circuit's general numerical threshold, Plaintiffs argue that practicability is the more important consideration in weighing 23(a)(1). *Id.* at 4 (citing *McLaughlin v. Liberty Mut. Ins. Co.*, 224 F.R.D. 304, 307 (D. Mass. 2004)). They argue that "[i]n order to determine whether joinder would be impracticable, 'courts give significant weight to such factors as the ability of class members to bring their own separate actions, their geographical diversity and the type of relief sought.'" *Id.* (quoting *Rolland*, 1999 WL 34815562, at *3). They argue that "it would be extremely difficult, and thus impracticable, for the members of the proposed class to maintain individual suits against [DHHS], particularly given the nature of their disabilities, their limited economic resources, their geographical diversity, and their segregation in nursing facilities." *Id.* at 6. Furthermore, they contend that the inability to precisely identify each individual class member and the likelihood that the class includes unnamed future members are factors making joinder less practicable. *Id.* at 5.

The Plaintiffs argue that second prerequisite for class certification is met because there are questions of law and fact common to the class. *Id.* at 6 (citing Fed.R.Civ.P. 23(a)(2)). They assert that "[b]ecause the class need share only a single legal or factual issue at this stage of the analysis, the commonality prerequisite is ordinarily easily satisfied." *Id.* (quoting *Mulligan v. Choice Mortg. Corp. USA*, No. CIV. 96-596-B, 1998 WL 544431, at *3 (D.N.H. Aug. 11, 1998)). They argue that although class members' individual circumstances differ, they all "challenge systemic issues with [DHHS's] policies and practices in the provision of services in nursing facilities and in the community." *Id.* at 7. Plaintiffs identify what they argue are questions of law and fact common to all putative class members. *See Id* at 7-8.

They argue that the third prerequisite to class certification is met because Plaintiffs' claims are typical of those of the class. *Id.* at 8 (citing Fed.R.Civ.P. 23(a)(3)). They contend that this requirement is met when the class representatives "possess the same interest and suffer the same injury" as other class members. *Id.* (quoting *Gen. Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 156 (1982)). Plaintiffs argue that the Named Plaintiffs, like all other class members, "have been inadequately screened and assessed under the NHRA, have been discriminated against in violation of the ADA and Section 504, and have not been provided services with 'reasonable promptness' under the Medicaid Act." *Id.* They contend that "[t]he fact that individual class members may have somewhat different needs, or may have entered the nursing homes through different processes, or may be entitled to or need different services, does not justify denying class certification." *Id.* (quoting *Rolland*, 1999 WL 34815562, at *7). Plaintiffs also cite *Rolland* for the proposition that the Named Plaintiffs' claims are typical of the class even though, subsequent to the filing of this action, they individually received some form of the evaluative screening they request as relief. *Id.* at 8-9.

Plaintiffs next argue that the Named Plaintiffs will "fairly and adequately protect the interests of the class," in satisfaction of the fourth prerequisite to class certification. *Id.* at 9 (citing Fed.R.Civ.P. 23(a)(4)). They identify three necessary elements: "The Court must inquire whether the Named Plaintiffs have the ability and the incentive to represent the claims of the class vigorously, that they have obtained adequate counsel, and that the Named Plaintiffs do not have interests adverse to the class." *Id.* (quoting *Rancourt v. Concannon*, 207 F.R.D. 14, 16 (D. Me. 2002)). Plaintiffs argue that the Named Plaintiffs have the incentive to represent the claims of the class because they "will benefit from the same injunction that is intended to benefit all class members." *Id.* (quoting *Risinger ex rel. Risinger v. Concannon*, 201 F.R.D. 16, 22 (D. Me. 2001)). They further contend that adequate counsel is "rebuttably presumed" and that Plaintiffs have obtained competent counsel. *Id.* (citing *Gomez v. Illinois State Bd. of Educ.*, 117 F.R.D. 394, 401 (N.D. Ill. 1987)). Finally, they assert that the Named Plaintiffs have suffered the same legal injury as the proposed class, so their interests are not

adverse to the class. *Id.* (citing *Curtis v. Comm'r Me. Dep't. of Human Services*, 159 F.R.D. 339, 341 (D. Me. 1994)).

The Plaintiffs acknowledge that they must satisfy one of three elements of Rule 23(b). They argue that the putative class satisfies 23(b)(2) because declaratory or injunctive relief is appropriate respecting the class as a whole. Quoting First Circuit law, the Plaintiffs explain, "the conduct complained of is the benchmark for determining whether a subdivision (b)(2) class exists, making it uniquely suited to civil rights actions." *Id.* (quoting *Yaffe v. Powers*, 454 F.2d 1362, 1366 (1st Cir. 1972)). The Plaintiffs note that this is a civil rights class action seeking declaratory and injunctive relief, which they argue "is exactly the type of litigation that . . . should be certified under Rule 23(b)(2)." *Id.* at 10. Furthermore, they argue that 23(b)(2) cases should be certified "where there is a danger that the individual's claim may be moot, [or] where a declaration of the rights of one plaintiff does not automatically translate into appropriate and timely relief for other class members . . . ." *Id.* (citing *Dionne v. Bouley*, 757 F.2d 1344, 1356 (1st Cir. 1985)). Plaintiffs warn that there is a danger of mootness in this case because DHHS attempted to address at least some of the claims after the filing of the initial complaint by screening the Named Plaintiffs. *Id.* They also argue that there is a risk that a declaration of the rights of one plaintiff will not resolve the problems of other class members because requiring the DHHS to fulfill its statutory requirements as to one individual will not resolve the systemic problems that are alleged. *See id.*

2. DHHS's Opposition

DHHS responds that Plaintiffs failed to satisfy the prerequisites of numerosity, commonality, and typicality under 23(a) and that they failed to demonstrate that a class action is appropriate under 23(b).

Turning to numerosity, DHHS argues that "the number of the unidentified proposed class members is unknown" and that the Court should deny class certification if it finds that "plaintiff's contention as to the size of the class is purely speculative." *Def.'s Opp'n.* at 5 (quoting *Vigue v. Ives*, 138 F.R.D. 6, 8 (D. Me. 1991)). DHHS puts the number of identified individuals in the class at thirty-seven.[3] *Id.* at 2. DHHS argues that the authority Plaintiffs cite for the proposition that a class of forty is generally sufficient to satisfy the numerosity requirement is "pure *dictum*, because the actual numbers of individuals cited in the classes under consideration in those cases were much higher." *Id.* at 6.

DHHS further argues that joinder of the plaintiffs is practicable. First, it states that "[j]oinder of potential class members is more likely to be found practicable where all class members can be easily identified." *Id.* (citing *Andrews v. Bechtel Power Corp.*, 780 F.2d 124 (1st Cir. 1985)). It argues that here "there is a discrete, relatively small number of individuals who have been personally identified." *Id.* at 6-7. Second, DHHS asserts that "where all members reside in a geographically compact area, joinder is more readily achieved." *Id.* at 7. They argue that the proposed class resides in a geographically compact area because thirty-four of the thirty-seven class members live in Southern Maine, which they define as "Penobscot County and south." *Id.* Third, DHHS predicts that the class will actually be smaller than thirty-seven since some of the thirty-seven will likely be satisfied with their current level of care, and Rule 23(c)(2)(B)(v) requires that individuals who do not wish to be part of the class be allowed to opt-out. *Id.*

DHHS next argues that the commonality requirement of 23(a)(2) is not met. *Id.* It divides Plaintiff's request for relief into two categories: 1) a procedural category, seeking an order that DHHS perform Pre-Admission Screening and Resident Review (PASRR) assessments; and 2) a substantive category, seeking an order that DHHS "provide appropriate placement and specialized services." *See Id.* It concedes that the former request is common for the entire class but asserts it has taken steps to provide this relief. *Id.* at 7-8. It submits that lack of a PASRR assessment alone "is not sufficient to support a class." *Id.* at 8. It argues that the latter request raises "no commonality because determinations of the appropriate specialized services and placement must be made on a client-by-client, case-by-case basis depending on the unique circumstances of each individual." *Id.*

DHHS argues that Rule 23(a)(3)'s typicality requirement is not met because "the [N]amed [P]laintiffs share very little connection with the identified proposed class members." *Id.* at 8-9. DHHS observes that the Named Plaintiffs are younger than most of the other identified members of the proposed class. *Id.* at 9. It argues that the original goals of their lawsuit were "to live and interact with people closer to their own age" and that those goals "would not apply to an individual in a nursing home in his or her later years of life." *Id.* DHHS further argues that the mental and physical conditions of the unidentified proposed class members are unknown, so the Named Plaintiffs "cannot demonstrate that their claims are typical of the unidentified proposed class." *Id.*

DHHS gives brief treatment to Plaintiffs' Rule 23(b)(2) argument, countering that it is not satisfied for the same reasons Rule 23(a)(2) commonality is not satisfied. *Id.*[4]

3. Plaintiffs' Reply

Plaintiffs reply that the class is sufficiently identified for class certification. *Pls.' Reply* at 2. It argues that the class definition is "virtually identical" to that of a class certified by the United States District Court for the District of Massachusetts in *Rolland*, "except that Plaintiffs have excluded individuals with mental retardation or autism, and have limited the class to those individuals with 'related conditions.'" *Id.* (citing *Rolland*, 1999 WL 34815562, at *2)). They argue that DHHS's characterization of the class as "broad and imprecise" is based on the premise that the class definition makes no reference to age or cerebral palsy, which DHHS saw as the focus of the initial complaint; yet Plaintiffs contend that DHHS "has acted or refused to act on grounds applicable to all with 'related conditions' (excluding autism), not just those with cerebral palsy." *Id.* Plaintiffs further argue that a Rule 23(b)(2) class "need not establish the precise number or identity of class members." *Id.* at 3 (quoting *Rolland*, 1999 WL 34815562, at *3).

Turning to numerosity, Plaintiffs refute DHHS's figure of thirty seven. *Id.* at 3. They argue that the class currently has at least forty members with cerebral palsy and up to eighteen members with epilepsy.[5] *Id.* Additionally, they maintain that the class is "fluid" and contains those who will enter a nursing facility at a later date. *Id.* Plaintiffs also contend that joinder is impracticable because class members are disabled, reside throughout the state, are not easily identifiable due to patient confidentiality concerns, and their participation in the needs-based Medicaid program indicates financial difficulty. *Id.* at 4.

Plaintiffs reject DHHS's contention that commonality is lacking because class members request individualized relief. They argue that they request an order that would put in place a system to address the individual needs of class members but "do not request that the Court approve a specific service." *Id.* They contend that "the Court has rejected similar arguments that differences in medical diagnoses and conditions undermine commonality and typicality." *Id.* at 4-5 (citing *Rancourt*, 207 F.R.D. at 15-16; and *Risinger*, 201 F.R.D. at 20-21).

Finally, Plaintiffs argue that DHHS's argument that differences in age between the Named Plaintiffs and the rest of the class lacks merit. *Id.* at 5. They assert individual's in their later years of life maintain their right to "live independently in the community," "to appropriate medical services," and to choose "where [they] live[] or whom [they] interact[] with." *Id.*

III. DISCUSSION

A. Class Certification Standard

Before certifying a class, the Court must review whether the Plaintiffs have met their burden of proving each

Rule 23(a) factor and one Rule 23(b) requirement. *Smilow v. Sw. Bell Mobile Sys., Inc.*, 323 F.3d 32, 38 (1st Cir. 2003). A court must "conduct a rigorous analysis of the prerequisites established by Rule 23 before certifying a class." *Id.* When legal and factual premises of a case are disputed, such that "the class action would be proper on one premise but not another," a district court "has the power to test disputed premises at the certification stage" by probing "behind the pleadings to formulate some prediction as to how specific issues will play out." *In re New Motor Vehicles Canadian Export Antitrust Litigation*, 522 F.3d 6, 17 (1st Cir. 2008) (internal punctuation and citations omitted). However, "the district court must evaluate the plaintiff's evidence . . . critically without allowing the defendant to turn the class-certification proceeding into an *unwieldy* trial on the merits." *In re PolyMedica Corp. Sec. Litig.*, 432 F.3d 1, 17 (1st Cir. 2005) (emphasis in original).

B. Rule 23(a) Factors

Rule 23(a) requires a showing of numerosity, commonality, typicality, and adequacy of representation. Fed.R.Civ.P. 23(a). DHHS contests numerosity, commonality, and typicality. Nevertheless, because the First Circuit directs district courts to undertake a "rigorous analysis," the Court addresses each requirement. *Smilow*, 323 F.3d at 38; *see In re Light Cigarettes Marketing Sales Practices Litigation*, No. 1:09-md-02068-JAW, 2010 WL 4901785, at *11-13 (D. Me. Nov. 24, 2010) (assessing all requirements even though numerosity and commonality were conceded), and *Donovan v. Philllip Morris USA, Inc.*, 268 F.R.D. 1, 10 (D. Mass. 2010) (assessing all requirements even though all four were conceded).

1. Numerosity

The numerosity requirement is satisfied when "the class is so numerous that joinder of all members is impracticable." Fed.R.Civ.P. 23(a)(1). There is no threshold number of class members that automatically satisfies this requirement. *Gen'l Tel. Co. Nw. v. EEOC*, 446 U.S. 318, 330 (1980). Nevertheless, the First Circuit has provided numerical suggestions. The First Circuit favorably cited authority holding numerosity is generally satisfied if "the potential number of plaintiffs exceeds 40." *Garcia-Rubiera*, 570 F.3d at 460 (quoting *Stewart v. Abraham*, 275 F.3d 220, 226-27 (3rd Cir. 2001)). Plaintiffs call this appellate comment dictum. Indeed, the forty class member figure was not directly relevant to that case as the plaintiff class in *Garcia-Rubiera* was estimated to be around 600, 000. Nevertheless, the forty class member figure is in line with decisions from many other circuits. *See* 5-23 Jerold L. Solovy, et al., Moore's Federal Practice, § 23.22 (Matthew Bender 3d ed.) ("a class of 41 or more is usually sufficiently numerous") (citing cases from the 3rd, 4th, 7th, 9th, 10th, and D.C. circuits). Given the weight of authority and its positive citation by the First Circuit, the figure of forty is a useful guide in considering how many class members meet the numerosity requirement.

Plaintiffs have provided evidence that the size of the class will include well over forty members. Plaintiffs cite deposition testimony and Maine government websites to demonstrate that there are at least forty individuals with cerebral palsy who fit the class definition. *Pls.' Mot.* at 3, 3 n.4. They further note there are a number of other individuals with epilepsy and other related conditions who are likely to fit the class definition. *Id.* at 3, 3 n.5. They cite statistics indicating that "there are new individuals entering nursing facilities each day who are at risk of the same rights violations and are members of the proposed class." *Id.* at 3. DHHS makes no attempt to undermine the statistical bases for Plaintiffs' figures. *See Def.'s Opp'n.* Instead, it argues for a deflated class size. The Court finds these arguments unconvincing.

First, DHHS discounts class members with related conditions other than cerebral palsy, arguing that the inclusion of class members with varying medical conditions makes the class "broad and imprecise." *Def.'s Opp'n.* at 3. This argument is better addressed to the consideration of commonality and typicality than to numerosity. The class definition incorporates specific statutory language that includes individuals with conditions other then cerebral palsy. 42 C.F.R. § 435.1010. DHHS essentially alters the class definition to shrink the size of the class. For purposes of

numerosity, the Court considers the size of the class as defined. If that definition does not satisfy other 23(a) requirements, certification can be denied on those grounds.

Second, DHHS's argument that the class will be smaller because class members must be given the opportunity to opt-out is simply incorrect. Under the plain language of Rule 23(c)(2)(B), the opt out requirement only applies to classes certified under 23(b)(3). Fed.R.Civ.P. 23(c)(2)(B); *Yaffe v. Powers*, 454 F.2d 1362, 1366 (1st Cir. 1972) ("notice to and therefore precise definition of the members of the suggested class are important to certification of a (b)(3) class, notice to the members of a (b)(2) class is not required and the actual membership of the class need not therefore be precisely delimited"). Here, because Plaintiffs attempt to certify the class under 23(b)(2), they need not give class members the opportunity to opt-out.

Third, *Vigue*, which DHHS cites in support of its assertion that the class size is speculative, is inapposite. In *Vigue*, the plaintiff failed to satisfy numerosity of a proposed class including "[a]ll persons residing in the State of Maine who are or will become eligible for both Medicaid and Medicare program benefits and who need or will need power or customized wheelchairs." 188 F.R.D. at 8. There, the plaintiff's only direct evidence of the number of proposed class members was a wheelchair dealer's testimony that she had rejected at least five individuals eligible for Medicaid and Medicare, *Id.* at 8. The plaintiff attempted to extrapolate that figure to fifty by offering an unsupported estimate that there were between ten and fifteen wheelchair dealers in Maine. *Id.* The Court considered this extrapolation too speculative to be considered evidence of a fifty member class. *Id.*

Here, Plaintiffs have provided direct evidence of at least forty class members. They have posited that the class includes additional unidentified class members, *Pls.' Mot.* at 5, but they do not rely on a specified number of unidentified class members to meet the numerosity requirement. The inclusion of unidentified class members merely serves to emphasize that the class is probably larger than the forty member figure for which Plaintiffs have provided direct evidence. *Yaffe* established that a Rule 23(b)(2) class need not precisely identify every class member, 454 F.2d at 1366, so Plaintiffs' failure to do so does not make the class overly speculative.

Although Plaintiffs' class is large enough to satisfy the First Circuit's advisory figure, further considerations go into the Rule 23(a)(1) analysis. "The facts and circumstances of each case are to be taken into account to determine numerosity under 23(a)(1)." *Andrews*, 780 F.2d at 131. Courts in the First Circuit have considered a number of factors in considering whether joinder of class members is impracticable. "Joinder is more likely to be practicable when class members are from the same geographic area" and "where class members can be easily identified." *Id.* 131-32. Furthermore, disability, confinement and financial difficulty, and the inability of class members to bring their own separate actions have been found to be factors strongly weighing against the practicability of joinder. *See Rolland*, 1999 WL 34815562, at *3.

The Court finds that joinder is not practicable in this case. The putative class members all suffer from disabilities as defined under the NHRA. Pursuant to the class definition, they are all either admitted to nursing facilities or candidates for admission. Their enrollment in MaineCare suggests their financial resources may be limited. These qualities would make it difficult for the putative class members to bring their own individual actions.

DHHS asserts that because most identified plaintiffs live in the southern half of Maine, geographic diversity does not make joinder impracticable. For support, DHHS cites *Andrews*. In *Andrews*, the First Circuit upheld the district court's finding of a lack of geographic diversity where the putative class members all lived in southeastern Massachusetts, 780 F.2d. at 132, a geographic area far more confined than "Southern Maine" if defined as DHHS does to include "Penobscot County and south". *Def.'s Opp'n. at 7.* Moreover, any number of unidentified members of the proposed class could live in the northern part of Maine. *See Risinger*, 201 F.R.D. at 19 ("geographic dispersion . . .

throughout the state of Maine" was a factor making joinder impracticable). Combining their location throughout Maine with the difficulties their disabilities may place on their ability to travel, the proposed class members' geographic dispersion weighs against the practicability of joinder.

Finally, because there are likely unidentified and future class members, there would be practical difficulties with identifying and joining all of the potential class members. *See Risinger*, 201 F.R.D. at 19. DHHS's characterization of the class as a "discrete, relatively small number of individuals who have been personally identified," *Def.'s Opp'n.* at 6-7, is based on its limited definition of the class. The class, as defined, is sufficiently numerous, fluid, and in all likelihood growing to meet the numerosity requirement.

2. Commonality

The commonality prerequisite is met when "there are questions of law or fact common to the class." Fed.R.Civ.P. 23 (a)(2). "Rule 23(a)'s requirement of commonality is a low bar." *In re New Motor Vehicles Canadian Export Antitrust Litig.*, 522 F.3d 6, 19. Here, questions of DHHS's course of conduct are common to all class members, namely its alleged failure to evaluate and provide services to the proposed class members according to federal standards. Those factual questions implicate a common set of federal statutes.

DHHS concedes that whether PASRR screenings have taken place is a common question, but argues that it is no longer relevant because DHHS has committed to putting in place an adequate PASRR system for the identified proposed class. It essentially asks the Court to ignore one of the Plaintiffs' claims by assuring the Court that it is being addressed. The Court cannot accept the State's unsupported assurance. Whether proper PASRR screenings are taking place remains at issue in this case, *see Pls.' Mot.* at 9 n.7, and as DHHS conceded, it is a common question. Furthermore, Plaintiffs do not ask the Court to order individualized remedies for the various class members. Instead, they seek an order requiring DHHS to develop a system of evaluation and implementation of corresponding services that complies with federal standards. In other words, class members seek relief from systemic barriers to proper treatment. This District has certified classes on nearly identical bases in the past. *See Rancourt*, 207 F.R.D. at 15-16; and *Risinger*, 201 F.R.D. at 20-21.

3. Typicality

The typicality prerequisite requires that "the claims or defenses of the representative parties are typical of the claims or defenses of the class." Fed.R.Civ.P. 23(a)(3). This requirement is satisfied when the representatives are "part of the class," *Falcon*, 457 U.S. at 156, and their claims "arise from the same event or practice or course of conduct that gives rise to the claims of other class members, and are based on the same legal theory," *Garcia-Rubiera*, 570 F.3d at 460 (internal quotations and punctuation omitted). Here, the representatives (the Named Plaintiffs) fit the class definition and assert the same legal claims as the other class members. Those legal claims are based on a common course of alleged conduct by DHHS.

DHHS's argument that the Named Plaintiffs are not typical of the rest of the class because they are younger than most class members is unavailing. DHHS provides no support for the notion that older individuals have less interest in proper medical services and independent living outside of a nursing facility than younger individuals. All class members, regardless of age, are entitled to receive care that is in compliance with federal law, and that is all Plaintiffs seek in this suit. The same can be said for class members with different conditions; whether they have cerebral palsy, epilepsy, or other related conditions, all class members are entitled to medical care that meets legal standards. That the Named Plaintiffs have cerebral palsy does not render their claims atypical of those class members who suffer from other conditions.

4. Adequacy

The adequacy prerequisite requires that the class representatives "fairly and adequately protect the interests of the class." Fed.R.Civ.P. 23(a)(4). Plaintiff must make a two-part showing: first, "that the interests of the representative party will not conflict with the interests of any of the class members, and second, that counsel chosen by the representative party is qualified, experienced and able to vigorously conduct the proposed litigation." *Andrews*, 780 F.2d at 130. DHHS does not contest this prerequisite. *See Def.'s Opp'n.* at 1. Nevertheless, the Court addresses this prerequisite pursuant to its obligation to conduct a rigorous analysis.

The Named Plaintiffs seek the same injunctive and declaratory relief for themselves that they seek for the class as a whole. Their willingness to bring the initial suit indicates that they are motivated to achieve such relief. As for adequacy of counsel, Plaintiffs' attorneys have filed declarations averring to their skill and experience in class action litigation and the underlying areas of substantive law. *Decl. of Jeffrey Nell Young* (Docket # 25); *Decl. of Martha Jane Perkins* (Docket # 26); *Decl. of Jack Comart* (Docket # 27); *Decl. of Staci Converse* (Docket # 28). The Court is satisfied that they are qualified and experienced. Because their interests are in line with the rest of the class and because they have retained qualified counsel, the Court concludes that the Named Plaintiffs will fairly and adequately protect the interests of the class.

C. Rule 23(b)(2)

Having satisfied all four of the Rule 23(a) prerequisites, Plaintiff must establish that DHHS "has acted or refused to act on grounds that apply generally to the class, so that injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed.R.Civ.P. 23(b)(2). "[T]he conduct complained of is the benchmark for determining whether a subdivision (b)(2) class exists, making it uniquely suited to civil rights actions in which members of the class are often incapable of specific enumeration." *Yaffe*, 454 F.2d at 1366. Plaintiffs allege a systemic problem with DHHS's procedures, and they seek injunctive and declaratory relief to change DHHS's conduct on an agency-wide basis. Such relief is appropriate respecting the whole class because if Plaintiffs' allegations prove correct, every putative class member will be entitled to the relief.

If the same relief could be obtained without class certification, the Court may be justified in denying class certification. *Dionne v. Bouley*, 757 F.2d 1344, 1356 (1st Cir. 1985). However, that possibility appears unlikely in this case. If the putative class members were to proceed on an individual basis, they might obtain the individual services they seek without obtaining systemic changes to DHHS's conduct that would benefit the class as a whole, a result that could lead to countless individual claims seeking the exact same relief. Obtaining relief on a class-wide basis ensures an efficient judicial remedy to any deficiency in DHHS's conduct.

Because Plaintiffs have satisfied the four prerequisites of Rule 23(a) and one element of Rule 23(b), class certification is appropriate.

IV. CONCLUSION

The Court GRANTS the Plaintiffs' Motion for Class Certification (Docket # 23).

SO ORDERED.

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Notes:

[1] The regulation defines "persons with related conditions" as:

Individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to-

(1) Cerebral palsy or epilepsy; or

(2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22.

(c) It is likely to continue indefinitely.

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-care.

(2) Understanding and use of language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

42 C.F.R. § 435.1010.

[2] The amended complaint also added a claim for relief under the "reasonable promptness" provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(8). *First Am. Class Action Compl.* ¶¶ 82-83 (Docket # 24) (*Class Action Compl.*).

[3] DHHS excludes the Named Plaintiffs in numbering the identified individuals in the class. *See Def.'s Opp'n.* at 2.

[4] DHHS also argues that 23(b)(3) is not satisfied. *Def.'s Opp'n.* at 9-10. However, Plaintiffs are only seeking certification under 23(b)(2). *Pls.' Reply* at 5 n.3. A party seeking class certification need only satisfy one of the Rule 23(b) elements. *See* Fed. R. Civ. P. 23(b). The Court does not reach DHHS's contentions regarding 23(b)(3).

[5] Plaintiffs assert that "there are currently 18 individuals enrolled in the MaineCare program who have epilepsy that manifested prior to age 22 residing in Maine nursing facilities who by definition would be included in the proposed class." *Pls.' Reply* at 3. However, they concede that they are unaware how many of those 18 "also have diagnoses of mental retardation, autism, dementia, or Alzheimer's Disease, which would eliminate them from the proposed class, or whether they also have a diagnosis of C[erebral] P[alsy]," in which case they would have been included in the forty-one figure. *Id.* at 3 n.5.

Olmstead v. L. C., 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540, 67 USLW 3683, 67 USLW 4567 (1999)

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527 U.S. 581 (1999)

119 S.Ct. 2176, 144 L.Ed.2d 540, 67 USLW 3683, 67 USLW 4567

OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, et al.

v.

L. C., by zimring, guardian ad litem and next friend, et al.

Case No. 98-536

United States Supreme Court

June 22, 1999

Argued April 21, 1999

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

Syllabus

In the Americans with Disabilities Act of 1990 (ADA), Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination. 42 U.S.C. §§ 12101(a)(2), (5). Title II of the ADA, which proscribes discrimination in the provision of public services, specifies, *inter alia*, that no qualified individual with a disability shall, "by reason of such disability," be excluded from participation in, or be denied the benefits of, a public entity's services, programs, or activities.§ 12132. Congress instructed the Attorney General to issue regulations implementing Title II's discrimination proscription. See § 12134(a). One such regulation, known as the "integration regulation," requires a "public entity [to] administer . . . programs . . . in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR § 35.130 (d). A further prescription, here called the "reasonable-modifications regulation," requires public entities to "make reasonable modifications" to avoid "discrimination on the basis of disability," but does not require measures that would "fundamentally alter" the nature of the entity's programs. § 35.130(b)(7).

Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women were voluntarily admitted to Georgia Regional

Hospital at Atlanta (GRH), where they were confined for treatment in a psychiatric unit. Although their treatment professionals eventually concluded that each of the women could be cared for appropriately in a community-based program, the women remained institutionalized at GRH. Seeking placement in community care, L. C. filed this suit against petitioner state officials (collectively, the State) under 42 U.S.C. § 1983 and Title II. She alleged that the State violated Title II in failing to place her in a community-based program once her treating professionals determined that such placement was appropriate. E. W. intervened, stating an identical claim. The District Court granted partial summary judgment for the women, ordering their

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placement in an appropriate community-based treatment program. The court rejected the State's argument that inadequate funding, not discrimination against L. C. and E. W. "by reason of [their] disabilit[ies]," accounted for their retention at GRH. Under Title II, the court concluded, unnecessary institutional segregation constitutes discrimination *per se*, which cannot be justified by a lack of funding. The court also rejected the State's defense that requiring immediate transfers in such cases would "fundamentally alter" the State's programs. The Eleventh Circuit affirmed the District Court's judgment, but remanded for reassessment of the State's cost-based defense. The District Court had left virtually no room for such a defense. The appeals court read the statute and regulations to allow the defense, but only in tightly limited circumstances. Accordingly, the Eleventh Circuit instructed the District Court to consider, as a key factor, whether the additional cost for treatment of L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget.

Held:

The judgment is affirmed in part and vacated in part, and the case is remanded.

138 F.3d 893, affirmed in part, vacated in part, and remanded.

Justice Ginsburg delivered the opinion of the Court with respect to Parts I, II, and III-A, concluding that, under Title II of the ADA, States are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. Pp. 596-603.

(a) The integration and reasonable-modifications regulations issued by the Attorney General rest on two key determinations: (1) Unjustified placement or retention of persons in institutions severely limits their exposure to the outside community, and therefore constitutes a form of discrimination based on disability prohibited by Title II, and (2) qualifying their obligation to avoid unjustified isolation of individuals with disabilities, States can resist modifications that would fundamentally alter the nature of their services and programs. The Eleventh Circuit essentially upheld the Attorney General's construction of the ADA. This Court affirms the Court of Appeals decision in

substantial part. Pp. 596-597.

(b) Undue institutionalization qualifies as discrimination "by reason of . . . disability." The Department of Justice has consistently advocated that it does. Because the Department is the agency directed

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by Congress to issue Title II regulations, its views warrant respect. This Court need not inquire whether the degree of deference described in *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844, is in order; the well-reasoned views of the agencies implementing a statute constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. *E. g., Bragdon v. Abbott*, 524 U.S. 624, 642. According to the State, L. C. and E. W. encountered no discrimination "by reason of" their disabilities because they were not denied community placement on account of those disabilities, nor were they subjected to "discrimination," for they identified no comparison class of similarly situated individuals given preferential treatment. In rejecting these positions, the Court recognizes that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA. The ADA stepped up earlier efforts in the Developmentally Disabled Assistance and Bill of Rights Act and the Rehabilitation Act of 1973 to secure opportunities for people with developmental disabilities to enjoy the benefits of community living. The ADA both requires all public entities to refrain from discrimination, see § 12132, and specifically identifies unjustified "segregation" of persons with disabilities as a "for[m] of discrimination," see §§ 12101(a)(2), 12101(a)(5). The identification of unjustified segregation as discrimination reflects two evident judgments: Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, cf., *e. g., Allen v. Wright*, 468 U.S. 737, 755; and institutional confinement severely diminishes individuals' everyday life activities. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice. The State correctly uses the past tense to frame its argument that, despite Congress' ADA findings, the Medicaid statute "reflected" a congressional policy preference for institutional treatment over treatment in the community. Since 1981, Medicaid has in fact provided funding for state-run home and community-based care through a waiver program. This Court emphasizes that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it. In this case, however, it is not genuinely disputed that L. C. and E. W. are individuals "qualified"

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for noninstitutional care: The State's own professionals determined that community-based treatment would be appropriate for L. C. and E. W., and neither woman opposed such treatment. Pp. 597-603.

Justice Ginsburg, joined by Justice O'Connor, Justice Souter, and Justice Breyer, concluded in Part III-B that the State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The reasonable-modifications regulation speaks of "reasonable modifications" to avoid discrimination, and allows States to resist modifications that entail a "fundamenta[l] alter[ation]" of the States' services and programs. If, as the Eleventh Circuit indicated, the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State's entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities. The ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State proposed, then retracted, for E. W. Some individuals, like L. C. and E. W. in prior years, may need institutional care from time to time to stabilize acute psychiatric symptoms. For others, no placement outside the institution may ever be appropriate. To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions. The case is remanded for further consideration of the appropriate relief, given the range of the State's facilities for the care of persons with diverse mental disabilities, and its obligation to administer services with an even hand. Pp. 603-606.

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Justice Stevens would affirm the judgment of the Court of Appeals, but because there are not five votes for that disposition, joined the Court's judgment and Parts I, II, and III-A of its opinion. Pp. 607-608.

Justice Kennedy concluded that the case must be remanded for a determination of the questions the Court poses and for a determination whether respondents can show a violation of 42 U.S.C. § 12132's ban on discrimination based on the summary judgment materials on file or any further pleadings and materials properly allowed. On the ordinary interpretation and meaning of the term, one who alleges discrimination must show that she received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic. Thus, respondents could demonstrate discrimination by showing that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness; (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating them instead in separate, locked institutional facilities). This

inquiry would not be simple. Comparisons of different medical conditions and the corresponding treatment regimens might be difficult, as would be assessments of the degree of integration of various settings in which medical treatment is offered. Thus far, respondents have identified no class of similarly situated individuals, let alone shown them to have been given preferential treatment. Without additional information, the Court cannot address the issue in the way the statute demands. As a consequence, the partial summary judgment granted respondents ought not to be sustained. In addition, it was error in the earlier proceedings to restrict the relevance and force of the State's evidence regarding the comparative costs of treatment. The State is entitled to wide discretion in adopting its own systems of cost analysis, and, if it chooses, to allocate health care resources based on fixed and overhead costs for whole institutions and programs. The lower courts should determine in the first instance whether a statutory violation is sufficiently alleged and supported in respondents' summary judgment materials and, if not, whether they should be given leave to replead and to introduce evidence and argument along the lines suggested. Pp. 611-615.

Ginsburg, J., announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, and III-A, in which Stevens, O'Connor, Souter, and Breyer, JJ., joined, and an opinion

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with respect to Part III-B, in which O'Connor, Souter, and Breyer, JJ., joined. Stevens, J., filed an opinion concurring in part and concurring in the judgment, *post*, p. 607. Kennedy, J., filed an opinion concurring in the judgment, in which Breyer, J., joined as to Part I, *post*, p. 608. Thomas, J., filed a dissenting opinion, in which Rehnquist, C. J., and Scalia, J., joined, *post*, p. 615.

Beverly Patricia Downing, Senior Assistant Attorney General of Georgia, argued the cause for petitioners. With her on the briefs were *Thurbert E. Baker*, Attorney General, *Kathleen M. Pacious*, Deputy Attorney General, *Jefferson James Davis*, Special Assistant Attorney General, and *Jeffrey S. Sutton*.

Michael H. Gottesman argued the cause for respondents. With him on the brief were *Steven D. Caley*, *Susan C. Jamieson*, and *David A. Webster*.

Irving L. Gornstein argued the cause for the United States as *amicus curiae* urging affirmance. With him on the brief were *Solicitor General Waxman*, *Acting Assistant Attorney General Lee*, *Deputy Solicitor General Underwood*, *Jessica Dunsay Silver*, and *Gregory B. Friel*.[*]

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Justice Ginsburg announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, and III-A, and an opinion with respect to Part III-B, in which Justice O'Connor, Justice Souter, and Justice Breyer join.

This case concerns the proper construction of the antidiscrimination provision contained in the public services portion (Title II) of the Americans with Disabilities Act of 1990 (ADA), 104 Stat. 337, 42 U.S.C. § 12132. Specifically, we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions. The answer, we hold, is a qualified yes. Such action is in order when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. In so ruling, we affirm the decision of the Eleventh Circuit in substantial part. We remand the case, however, for further consideration of the appropriate relief, given the range of facilities the State maintains for the care and treatment of persons with diverse mental disabilities, and its obligation to administer services with an even hand.

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I

This case, as it comes to us, presents no constitutional question. The complaints filed by plaintiffs-respondents L. C. and E. W. did include such an issue; L. C. and E. W. alleged that defendants-petitioners, Georgia health care officials, failed to afford them minimally adequate care and freedom from undue restraint, in violation of their rights under the Due Process Clause of the Fourteenth Amendment. See Complaint ¶¶ 87-91; Intervenor's Complaint ¶¶ 30-34. But neither the District Court nor the Court of Appeals reached those Fourteenth Amendment claims. See Civ. No. 1:95-cv-1210-MHS (ND Ga., Mar. 26, 1997), pp. 5-6, 11-13, App. to Pet. for Cert. 34a-35a, 40a-41a; 138 F.3d 893, 895, and n. 3 (CA11 1998). Instead, the courts below resolved the case solely on statutory grounds. Our review is similarly confined. Cf. *Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 450 (1985) (Texas city's requirement of special use permit for operation of group home for mentally retarded, when other care and multiple-dwelling facilities were freely permitted, lacked rational basis and therefore violated Equal Protection Clause of Fourteenth Amendment). Mindful that it is a statute we are construing, we set out first the legislative and regulatory prescriptions on which the case turns.

In the opening provisions of the ADA, Congress stated findings applicable to the statute in all its parts. Most relevant to this case, Congress determined that

> "(2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;
>
> "(3) discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization . . . ;
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> . . . .

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"(5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, . . . failure to make modifications to existing facilities and practices, . . . [and] segregation . . . ." 42 U.S.C. §§ 12101(a)(2), (3), (5).[1]

Congress then set forth prohibitions against discrimination in employment (Title I, §§ 12111-12117), public services furnished by governmental entities (Title II, §§ 12131-12165), and public accommodations provided by private entities (Title III, §§ 12181-12189). The statute as a whole is intended "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." § 12101(b)(1).[2]

This case concerns Title II, the public services portion of the ADA.[3] The provision of Title II centrally at issue reads:

"Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such

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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." § 201, as set forth in 42 U.S.C. § 12132.

Title II's definition section states that "public entity" includes "any State or local government," and "any department, agency, [or] special purpose district." §§ 12131(1)(A),(B). The same section defines "qualified individual with a disability" as

"an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." § 12131(2).

On redress for violations of § 12132's discrimination prohibition, Congress referred to remedies available under § 505 of the Rehabilitation Act of 1973, 92 Stat. 2982, 29 U.S.C. § 794a. See § 203, as set forth in 42 U.S.C. § 12133 ("The remedies, procedures, and rights set forth in [§ 505 of the Rehabilitation Act] shall be the remedies, procedures, and rights this subchapter provides to any person alleging discrimination on the basis of disability in violation of section 12132 of this title.").[4]

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Congress instructed the Attorney General to issue regulations implementing provisions of Title II, including § 12132's discrimination proscription. See § 204, as set forth in § 12134(a) ("[T]he Attorney General shall promulgate regulations in an accessible format that implement this part.").[5] The Attorney General's regulations,

Congress further directed, "shall be consistent with this chapter and with the coordination regulations . . . applicable to recipients of Federal financial assistance under [§ 504 of the Rehabilitation Act]." § 204, as set forth in 42 U.S.C. § 12134(b). One of the § 504 regulations requires recipients of federal funds to "administer programs and activities in the most integrated

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setting appropriate to the needs of qualified handicapped persons." 28 CFR § 41.51(d) (1998).

As Congress instructed, the Attorney General issued Title II regulations, see 28 CFR pt. 35 (1998), including one modeled on the § 504 regulation just quoted; called the "integration regulation," it reads:

> "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR § 35.130(d) (1998).

The preamble to the Attorney General's Title II regulations defines "the most integrated setting appropriate to the needs of qualified individuals with disabilities" to mean "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 CFR pt. 35, App. A, p. 450 (1998). Another regulation requires public entities to "make reasonable modifications" to avoid "discrimination on the basis of disability," unless those modifications would entail a "fundamenta[l] alter[ation]"; called here the "reasonable-modifications regulation," it provides:

"A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 CFR § 35.130(b)(7) (1998).

We recite these regulations with the caveat that we do not here determine their validity. While the parties differ on the proper construction and enforcement of the regulations, we do not understand petitioners to challenge the regulatory formulations themselves as outside the congressional authorization. See Brief for Petitioners 16-17, 36, 40-41;

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Reply Brief 15-16 (challenging the Attorney General's interpretation of the integration regulation).

II

With the key legislative provisions in full view, we summarize the facts underlying this dispute. Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W. with a personality disorder. Both women have a history of treatment in institutional settings. In May 1992, L. C.

was voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH), where she was confined for treatment in a psychiatric unit. By May 1993, her psychiatric condition had stabilized, and L. C.'s treatment team at GRH agreed that her needs could be met appropriately in one of the community-based programs the State supported. Despite this evaluation, L. C. remained institutionalized until February 1996, when the State placed her in a community-based treatment program.

E. W. was voluntarily admitted to GRH in February 1995; like L. C., E. W. was confined for treatment in a psychiatric unit. In March 1995, GRH sought to discharge E. W. to a homeless shelter, but abandoned that plan after her attorney filed an administrative complaint. By 1996, E. W.'s treating psychiatrist concluded that she could be treated appropriately in a community-based setting. She nonetheless remained institutionalized until a few months after the District Court issued its judgment in this case in 1997.

In May 1995, when she was still institutionalized at GRH, L. C. filed suit in the United States District Court for the Northern District of Georgia, challenging her continued confinement in a segregated environment. Her complaint invoked 42 U.S.C. § 1983 and provisions of the ADA, §§ 12131-12134, and named as defendants, now petitioners, the Commissioner of the Georgia Department of Human Resources, the Superintendent of GRH, and the Executive Director of the Fulton County Regional Board (collectively,

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the State). L. C. alleged that the State's failure to place her in a community-based program, once her treating professionals determined that such placement was appropriate, violated, *inter alia*, Title II of the ADA. L. C.'s pleading requested, among other things, that the State place her in a community care residential program, and that she receive treatment with the ultimate goal of integrating her into the mainstream of society. E. W. intervened in the action, stating an identical claim.[6]

The District Court granted partial summary judgment in favor of L. C. and E. W. See App. to Pet. for Cert. 31a-42a. The court held that the State's failure to place L. C. and E. W. in an appropriate community-based treatment program violated Title II of the ADA. See *id.*, at 39a, 41a. In so ruling, the court rejected the State's argument that inadequate funding, not discrimination against L. C. and E. W. "by reason of" their disabilities, accounted for their retention at GRH. Under Title II, the court concluded, "unnecessary institutional segregation of the disabled constitutes discrimination *per se*, which cannot be justified by a lack of funding." *Id.*, at 37a.

In addition to contending that L. C. and E. W. had not shown discrimination "by reason of [their] disabilit [ies]," the State resisted court intervention on the ground that requiring immediate transfers in cases of this order would "fundamentally alter" the State's activity. The State reasserted that it was already using all available funds to provide services to other persons with disabilities. See *id.*, at 38a. Rejecting

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the State's "fundamental alteration" defense, the court observed that existing state programs provided community-based treatment of the kind for which L. C. and E. W. qualified, and that the State could "provide services

to plaintiffs in the community at considerably *less* cost than is required to maintain them in an institution." *Id.*, at 39a.

The Court of Appeals for the Eleventh Circuit affirmed the judgment of the District Court, but remanded for reassessment of the State's cost-based defense. See 138 F.3d, at 905. As the appeals court read the statute and regulations: When "a disabled individual's treating professionals find that a community-based placement is appropriate for that individual, the ADA imposes a duty to provide treatment in a community setting—the most integrated setting appropriate to that patient's needs"; "[w]here there is no such finding [by the treating professionals], nothing in the ADA requires the deinstitutionalization of th[e] patient." *Id.*, at 902.

The Court of Appeals recognized that the State's duty to provide integrated services "is not absolute"; under the Attorney General's Title II regulation, "reasonable modifications" were required of the State, but fundamental alterations were not demanded. *Id.*, at 904. The appeals court thought it clear, however, that "Congress wanted to permit a cost defense only in the most limited of circumstances." *Id.*, at 902. In conclusion, the court stated that a cost justification would fail "[u]nless the State can prove that requiring it to [expend additional funds in order to provide L. C. and E. W. with integrated services] would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service [the State] provides." *Id.*, at 905. Because it appeared that the District Court had entirely ruled out a "lack of funding" justification, see App. to Pet. for Cert. 37a, the appeals court remanded, repeating that the District Court should consider, among other things, "whether the additional expenditures necessary to treat L. C. and E. W. in community-based care would be unreasonable

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given the demands of the State's mental health budget." 138 F.3d, at 905.[7]

We granted certiorari in view of the importance of the question presented to the States and affected individuals. See 525 U.S. 1054 (1998).[8]

III

Endeavoring to carry out Congress' instruction to issue regulations implementing Title II, the Attorney General, in the integration and reasonable-modifications regulations, see *supra*, at 591-592, made two key determinations. The first concerned the scope of the ADA's discrimination proscription, 42 U.S.C. § 12132; the second concerned the obligation of the States to counter discrimination. As to the first, the Attorney General concluded that unjustified placement or retention of persons in institutions, severely limiting their exposure to the outside community, constitutes a form of discrimination based on disability prohibited by Title II. See 28 CFR § 35.130(d) (1998) ("A public entity shall administer services . . . in the most integrated setting appropriate to the needs of qualified individuals with disabilities."); Brief for United States as *Amicus Curiae* in *Helen L. v. DiDario*, No. 94-1243 (CA3 1994), pp. 8, 15-16 (unnecessary segregation of persons with disabilities constitutes a form of discrimination prohibited by the ADA and the integration

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regulation). Regarding the States' obligation to avoid unjustified isolation of individuals with disabilities, the Attorney General provided that States could resist modifications that "would fundamentally alter the nature of the service, program, or activity." 28 CFR §35.130(b)(7) (1998).

The Court of Appeals essentially upheld the Attorney General's construction of the ADA. As just recounted, see *supra*, at 595-596, the appeals court ruled that the unjustified institutionalization of persons with mental disabilities violated Title II; the court then remanded with instructions to measure the cost of caring for L. C. and E. W. in a community-based facility against the State's mental health budget.

We affirm the Court of Appeals' decision in substantial part. Unjustified isolation, we hold, is properly regarded as discrimination based on disability. But we recognize, as well, the States' need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States' obligation to administer services with an even hand. Accordingly, we further hold that the Court of Appeals' remand instruction was unduly restrictive. In evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably.

A

We examine first whether, as the Eleventh Circuit held, undue institutionalization qualifies as discrimination "by reason of . . . disability." The Department of Justice has consistently advocated that it does.[9] Because the Department

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is the agency directed by Congress to issue regulations implementing Title II, see *supra*, at 591-592, its views warrant respect. We need not inquire whether the degree of deference described in *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984), is in order; "[i]t is enough to observe that the well-reasoned views of the agencies implementing a statute 'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.' " *Bragdon v. Abbott*, 524 U.S. 624, 642 (1998) (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 139-140 (1944)).

The State argues that L. C. and E. W. encountered no discrimination "by reason of" their disabilities because they were not denied community placement on account of those disabilities. See Brief for Petitioners 20. Nor were they subjected to "discrimination," the State contends, because " 'discrimination' necessarily requires uneven treatment of similarly situated individuals," and L. C. and E. W. had identified no comparison class, *i. e.*, no similarly situated individuals given preferential treatment. *Id.*, at 21. We are satisfied that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA.[10]

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The ADA stepped up earlier measures to secure opportunities for people with developmental disabilities to enjoy the benefits of community living. The Developmentally Disabled Assistance and Bill of Rights Act, a 1975 measure, stated in aspirational terms that "[t]he treatment, services, and habilitation for a person with developmental disabilities . . . *should be* provided in the setting that is least restrictive of the person's personal liberty." 89 Stat. 502, 42 U.S.C. § 6010(2) (1976 ed.) (emphasis added); see also *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 24 (1981) (concluding that the § 6010 provisions "were intended to be hortatory, not mandatory"). In a related legislative endeavor, the Rehabilitation Act of 1973, Congress used mandatory language to proscribe discrimination against persons with disabilities. See 87 Stat. 394, as amended, 29 U.S.C. § 794 (1976 ed.) ("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

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financial assistance." (Emphasis added.)) Ultimately, in the ADA, enacted in 1990, Congress not only required all public entities to refrain from discrimination, see 42 U.S.C. § 12132; additionally, in findings applicable to the entire statute, Congress explicitly identified unjustified "segregation" of persons with disabilities as a "for[m] of discrimination." See § 12101(a)(2) ("historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem"); § 12101(a)(5) ("individuals with disabilities continually encounter various forms of discrimination, including . . . segregation").[11]

Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Cf. *Allen v. Wright*, 468 U.S. 737, 755 (1984) ("There can be no doubt that [stigmatizing injury often caused by racial discrimination] is one of the most serious consequences of discriminatory government action."); *Los Angeles Dept. of Water and Power v. Manhart*, 435 U.S. 702, 707, n. 13 (1978) (" 'In forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.' " (quoting *Sprogis v. United Air Lines, Inc.*, 444 F.2d 1194, 1198 (CA7

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1971)). Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. See Brief for American Psychiatric Association et al. as *Amici Curiae* 20-22. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice. See Brief for United States as *Amicus Curiae* 6-7, 17.

The State urges that, whatever Congress may have stated as its findings in the ADA, the Medicaid statute "reflected a congressional policy preference for treatment in the institution over treatment in the community." Brief for Petitioners 31. The State correctly used the past tense. Since 1981, Medicaid has provided funding for state-run home and community-based care through a waiver program. See 95 Stat. 812-813, as amended, 42 U.S.C. § 1396n (c); Brief for United States as *Amicus Curiae* 20-21.[12] Indeed, the United States points out that the Department of Health and Human Services (HHS) "has a policy of encouraging States to take advantage of the waiver program, and often approves more waiver slots than a State ultimately uses." *Id.*, at 25-26 (further observing that, by 1996, "HHS approved up to 2109 waiver slots for Georgia, but Georgia used only 700").

We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community

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settings. Title II provides only that "qualified individual[s] with a disability" may not "be subjected to discrimination." 42 U.S.C. § 12132. "Qualified individuals," the ADA further explains, are persons with disabilities who, "with or without reasonable modifications to rules, policies, or practices, . . . mee[t] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." § 12131(2).

Consistent with these provisions, the State generally may rely on the reasonable assessments of its own professionals in determining whether an individual "meets the essential eligibility requirements" for habilitation in a community-based program. Absent such qualification, it would be inappropriate to remove a patient from the more restrictive setting. See 28 CFR § 35.130(d) (1998) (public entity shall administer services and programs in "the most integrated setting *appropriate* to the needs of qualified individuals with disabilities" (emphasis added)); cf. *School Bd. of Nassau Cty. v. Arline*, 480 U.S. 273, 288 (1987) ("[C]ourts normally should defer to the reasonable medical judgments of public health officials.").[13] Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it. See 28 CFR § 35.130(e)(1) (1998) ("Nothing in this part shall be construed to require an individual with a disability to accept an accommodation . . . which such individual chooses not to accept."); 28 CFR pt. 35, App. A, p. 450 (1998) ("[P]ersons with disabilities must be provided the option of declining to accept a particular accommodation."). In this case, however, there is no genuine dispute concerning the status of L. C. and E. W. as individuals "qualified"

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for noninstitutional care: The State's own professionals determined that community-based treatment would be appropriate for L. C. and E. W., and neither woman opposed such treatment. See *supra*, at 593.[14]

B

The State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The reasonable-modifications regulation speaks of "reasonable modifications" to avoid

discrimination, and allows States to resist modifications that entail a "fundamental[l] alter[ation]" of the States' services and programs. 28 CFR § 35.130(b)(7) (1998). The Court of Appeals construed this regulation to permit a cost-based defense "only in the most limited of circumstances," 138 F.3d, at 902, and remanded to the District Court to consider, among other things, "whether the additional expenditures necessary to treat L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget," *Id.*, at 905.

The Court of Appeals' construction of the reasonable-modifications regulation is unacceptable for it would leave the State virtually defenseless once it is shown that the plaintiff is qualified for the service or program she seeks. If the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State's entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. See Tr. of Oral Arg. 27 (State's attorney argues that Court of Appeals' understanding of the

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fundamental-alteration defense, as expressed in its order to the District Court, "will always preclude the State from a meaningful defense"); cf. Brief for Petitioners 37-38 (Court of Appeals' remand order "mistakenly asks the district court to examine [the fundamental-alteration] defense based on the cost of providing community care to just two individuals, not all Georgia citizens who desire community care"); 1:95-cv-1210-MHS (ND Ga., Oct. 20, 1998), p. 3, App. 177 (District Court, on remand, declares the impact of its decision beyond L. C. and E. W. "irrelevant"). Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.

When it granted summary judgment for plaintiffs in this case, the District Court compared the cost of caring for the plaintiffs in a community-based setting with the cost of caring for them in an institution. That simple comparison showed that community placements cost less than institutional confinements. See App. to Pet. for Cert. 39a. As the United States recognizes, however, a comparison so simple overlooks costs the State cannot avoid; most notably, a "State . . . may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions." Brief for United States as *Amicus Curiae* 21.[15]

As already observed, see *supra*, at 601-602, the ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Cf. *post*, at

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610 (Kennedy, J., concurring in judgment). Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State proposed, then retracted, for E. W. See *supra*, at 593. Some individuals, like L. C. and E. W. in prior years, may need institutional care from time to time "to stabilize acute psychiatric symptoms," App. 98 (affidavit of Dr. Richard L. Elliott); see 138 F.3d, at

903 ("[T]here may be times [when] a patient can be treated in the community, and others whe[n] an institutional placement is necessary."); Reply Brief 19 (placement in a community-based treatment program does not mean the State will no longer need to retain hospital accommodations for the person so placed). For other individuals, no placement outside the institution may ever be appropriate. See Brief for American Psychiatric Association et al. as *Amici Curiae* 22-23 ("Some individuals, whether mentally retarded or mentally ill, are not prepared at particular times—perhaps in the short run, perhaps in the long run—for the risks and exposure of the less protective environment of community settings"; for these persons, "institutional settings are needed and must remain available."); Brief for Voice of the Retarded et al. as *Amici Curiae* 11 ("Each disabled person is entitled to treatment in the most integrated setting possible for that person—recognizing that, on a case-by-case basis, that setting may be in an institution."); *Youngberg v. Romeo*, 457 U.S. 307, 327 (1982) (Blackmun, J., concurring) ("For many mentally retarded people, the difference between the capacity to do things for themselves within an institution and total dependence on the institution for all of their needs is as much liberty as they ever will know.").

To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan

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for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. See Tr. of Oral Arg. 5 (State's attorney urges that, "by asking [a] person to wait a short time until a community bed is available, Georgia does not exclude [that] person by reason of disability, neither does Georgia discriminate against her by reason of disability"); see also *id.*, at 25 ("[I]t is reasonable for the State to ask someone to wait until a community placement is available."). In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions.[16]

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For the reasons stated, we conclude that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. The judgment of the Eleventh Circuit is therefore affirmed in part and vacated in part, and the case is remanded for further proceedings.

It is so ordered.

Justice Stevens, concurring in part and concurring in the judgment.

Unjustified disparate treatment, in this case, "unjustified institutional isolation," constitutes discrimination under the Americans with Disabilities Act of 1990. See *ante*, at 600. If a plaintiff requests relief that requires modification of a State's services or programs, the State may assert, as an affirmative defense, that the requested modification would cause a fundamental alteration of a State's services and programs. In this case, the Court of Appeals appropriately remanded for consideration of the State's affirmative defense. On remand, the District Court rejected the State's "fundamental-alteration defense." See *ante*, at 596, n. 7. If the District Court was wrong in concluding that costs unrelated to the treatment of L. C. and E. W. do not support such a defense in this case, that arguable error should be corrected either by the Court of Appeals or by this Court in review of that decision. In my opinion, therefore, we should simply affirm the judgment of the Court of Appeals.

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But because there are not five votes for that disposition, I join the Court's judgment and Parts I, II, and III-A of its opinion. Cf. *Bragdon v. Abbott*, 524 U.S. 624, 655-656(1998) (Stevens, J., concurring); *Screws v. United States*, 325 U.S. 91, 134 (1945) (Rutledge, J., concurring in result).

Justice Kennedy, with whom Justice Breyer joins as to Part I, concurring in the judgment.

I

Despite remarkable advances and achievements by medical science, and agreement among many professionals that even severe mental illness is often treatable, the extent of public resources to devote to this cause remains controversial. Knowledgeable professionals tell us that our society, and the governments which reflect its attitudes and preferences, have yet to grasp the potential for treating mental disorders, especially severe mental illness. As a result, necessary resources for the endeavor often are not forthcoming. During the course of a year, about 5.6 million Americans will suffer from severe mental illness. E. Torrey, Out of the Shadows 4 (1997). Some 2.2 million of these persons receive no treatment. *Id.*, at 6. Millions of other Americans suffer from mental disabilities of less serious degree, such as mild depression. These facts are part of the background against which this case arises. In addition, of course, persons with mental disabilities have been subject to historic mistreatment, indifference, and hostility. See, *e. g.*, *Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 461-464 (1985) (Marshall, J., concurring in judgment in part and dissenting in part) (discussing treatment of the mentally retarded).

Despite these obstacles, the States have acknowledged that the care of the mentally disabled is their special obligation. They operate and support facilities and programs, sometimes elaborate ones, to provide care. It is a continuing

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challenge, though, to provide the care in an effective and humane way, particularly because societal attitudes and the responses of public authorities have changed from time to time.

Beginning in the 1950's, many victims of severe mental illness were moved out of state-run hospitals, often with benign objectives. According to one estimate, when adjusted for population growth, "the actual decrease in the numbers of people with severe mental illnesses in public psychiatric hospitals between 1955 and 1994 was 92 percent." Brief for American Psychiatric Association et al. as *Amici Curiae* 21, n. 5 (citing Torrey, *supra*, at 8-9). This was not without benefit or justification. The so-called "deinstitutionalization" has permitted a substantial number of mentally disabled persons to receive needed treatment with greater freedom and dignity. It may be, moreover, that those who remain institutionalized are indeed the most severe cases. With reference to this case, as the Court points out, *ante*, at 593, 603, it is undisputed that the State's own treating professionals determined that community-based care was medically appropriate for respondents. Nevertheless, the depopulation of state mental hospitals has its dark side. According to one expert:

> "For a substantial minority . . . deinstitutionalization has been a psychiatric *Titanic*. Their lives are virtually devoid of 'dignity' or 'integrity of body, mind, and spirit.' 'Self-determination' often means merely that the person has a choice of soup kitchens. The 'least restrictive setting' frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies." Torrey, *supra*, at 11.

It must be remembered that for the person with severe mental illness who has no treatment the most dreaded of confinements can be the imprisonment inflicted by his own mind,

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which shuts reality out and subjects him to the torment of voices and images beyond our own powers to describe.

It would be unreasonable, it would be a tragic event, then, were the Americans with Disabilities Act of 1990 (ADA) to be interpreted so that States had some incentive, for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision. The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference. It is a common phenomenon that a patient functions well with medication, yet, because of the mental illness itself, lacks the discipline or capacity to follow the regime the medication requires. This is illustrative of the factors a responsible physician will consider in recommending the appropriate setting or facility for treatment. Justice Ginsburg's opinion takes account of this background. It is careful, and quite correct, to say that it is not "the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter . . . ." *Ante*, at 605.

In light of these concerns, if the principle of liability announced by the Court is not applied with caution and circumspection, States may be pressured into attempting compliance on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition. This danger is in addition to the federalism costs inherent in referring state decisions regarding the administration of treatment programs and the allocation of resources to the reviewing authority of the federal courts. It is of central importance, then, that courts apply today's decision with great deference to the medical decisions of the responsible, treating physicians and, as the Court makes clear, with appropriate deference to the program funding decisions of state policymakers.

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II

With these reservations made explicit, in my view we must remand the case for a determination of the questions the Court poses and for a determination whether respondents can show a violation of 42 U.S.C. § 12132's ban on discrimination based on the summary judgment materials on file or any further pleadings and materials properly allowed.

At the outset it should be noted there is no allegation that Georgia officials acted on the basis of animus or unfair stereotypes regarding the disabled. Underlying much discrimination law is the notion that animus can lead to false and unjustified stereotypes, and vice versa. Of course, the line between animus and stereotype is often indistinct, and it is not always necessary to distinguish between them. Section 12132 can be understood to deem as irrational, and so to prohibit, distinctions by which a class of disabled persons, or some within that class, are, by reason of their disability and without adequate justification, exposed by a state entity to more onerous treatment than a comparison group in the provision of services or the administration of existing programs, or indeed entirely excluded from state programs or facilities. Discrimination under this statute might in principle be shown in the case before us, though further proceedings should be required.

Putting aside issues of animus or unfair stereotype, I agree with Justice Thomas that on the ordinary interpretation and meaning of the term, one who alleges discrimination must show that she "received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic." *Post,* at 616 (dissenting opinion). In my view, however, discrimination so defined might be shown here. Although the Court seems to reject Justice Thomas' definition of discrimination, *ante,* at 598, it asserts that unnecessary institutional care does lead to "[d]issimilar treatment," *ante,* at 601. According to the Court, "[i]n order to receive needed medical services, persons with mental

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disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice." *Ibid.*

Although this point is not discussed at length by the Court, it does serve to suggest the theory under which respondents might be subject to discrimination in violation of § 12132. If they could show that persons needing psychiatric or other medical services to treat a mental disability are subject to a more onerous condition than are persons eligible for other existing state medical services, and if removal of the condition would not be a fundamental alteration of a program or require the creation of a new one, then the beginnings of a discrimination case would be established. In terms more specific to this case, if respondents could show that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness, (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating

them instead in separate, locked institutional facilities), I believe it would demonstrate discrimination on the basis of mental disability.

Of course, it is a quite different matter to say that a State without a program in place is required to create one. No State has unlimited resources, and each must make hard decisions on how much to allocate to treatment of diseases and disabilities. If, for example, funds for care and treatment of the mentally ill, including the severely mentally ill, are reduced in order to support programs directed to the treatment and care of other disabilities, the decision may be unfortunate. The judgment, however, is a political one and not within the reach of the statute. Grave constitutional concerns are raised when a federal court is given the authority

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to review the State's choices in basic matters such as establishing or declining to establish new programs. It is not reasonable to read the ADA to permit court intervention in these decisions. In addition, as the Court notes, *ante*, at 592, by regulation a public entity is required only to make "reasonable modifications in policies, practices, or procedures" when necessary to avoid discrimination and is not even required to make those if "the modifications would fundamentally alter the nature of the service, program, or activity." 28 CFR § 35.130(b)(7) (1998). It follows that a State may not be forced to create a community-treatment program where none exists. See Brief for United States as *Amicus Curiae* 19-20, and n. 3. Whether a different statutory scheme would exceed constitutional limits need not be addressed.

Discrimination, of course, tends to be an expansive concept and, as legal category, it must be applied with care and prudence. On any reasonable reading of the statute, § 12132 cannot cover all types of differential treatment of disabled and non disabled persons, no matter how minimal or innocuous. To establish discrimination in the context of this case, and absent a showing of policies motivated by improper animus or stereotypes, it would be necessary to show that a comparable or similarly situated group received differential treatment. Regulations are an important tool in identifying the kinds of contexts, policies, and practices that raise concerns under the ADA. The congressional findings in 42 U.S.C. § 12101 also serve as a useful aid for courts to discern the sorts of discrimination with which Congress was concerned. Indeed, those findings have clear bearing on the issues raised in this case, and support the conclusion that unnecessary institutionalization may be the evidence or the result of the discrimination the ADA prohibits.

Unlike Justice Thomas, I deem it relevant and instructive that Congress in express terms identified the "isolat[ion] and segregat[ion]" of disabled persons by society as a "for[m]

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of discrimination," §§ 12101(a)(2), (5), and noted that discrimination against the disabled "persists in such critical areas as . . . institutionalization," § 12101(a)(3). These findings do not show that segregation and institutionalization are always discriminatory or that segregation or institutionalization are, by their nature, forms of prohibited discrimination. Nor do they necessitate a regime in which individual treatment plans are required, as distinguished from broad and reasonable classifications for the provision of health care services. Instead, they

underscore Congress' concern that discrimination has been a frequent and pervasive problem in institutional settings and policies and its concern that segregating disabled persons from others can be discriminatory. Both of those concerns are consistent with the normal definition of discrimination—differential treatment of similarly situated groups. The findings inform application of that definition in specific cases, but absent guidance to the contrary, there is no reason to think they displace it. The issue whether respondents have been discriminated against under § 12132 by institutionalized treatment cannot be decided in the abstract, divorced from the facts surrounding treatment programs in their State.

The possibility therefore remains that, on the facts of this case, respondents would be able to support a claim under § 12132 by showing that they have been subject to discrimination by Georgia officials on the basis of their disability. This inquiry would not be simple. Comparisons of different medical conditions and the corresponding treatment regimens might be difficult, as would be assessments of the degree of integration of various settings in which medical treatment is offered. For example, the evidence might show that, apart from services for the mentally disabled, medical treatment is rarely offered in a community setting but also is rarely offered in facilities comparable to state mental hospitals. Determining the relevance of that type of evidence would require considerable judgment and analysis.

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However, as petitioners observe, "[i]n this case, no class of similarly situated individuals was even identified, let alone shown to be given preferential treatment." Brief for Petitioners 21. Without additional information regarding the details of state-provided medical services in Georgia, we cannot address the issue in the way the statute demands. As a consequence, the judgment of the courts below, granting partial summary judgment to respondents, ought not to be sustained. In addition, as Justice Ginsburg's opinion is careful to note, *ante*, at 604, it was error in the earlier proceedings to restrict the relevance and force of the State's evidence regarding the comparative costs of treatment. The State is entitled to wide discretion in adopting its own systems of cost analysis, and, if it chooses, to allocate health care resources based on fixed and overhead costs for whole institutions and programs. We must be cautious when we seek to infer specific rules limiting States' choices when Congress has used only general language in the controlling statute.

I would remand the case to the Court of Appeals or the District Court for it to determine in the first instance whether a statutory violation is sufficiently alleged and supported in respondents' summary judgment materials and, if not, whether they should be given leave to replead and to introduce evidence and argument along the lines suggested above.

For these reasons, I concur in the judgment of the Court.

Justice Thomas, with whom The Chief Justice and Justice Scalia join, dissenting.

Title II of the Americans with Disabilities Act of 1990 (ADA), 104 Stat. 337, as set forth in 42 U.S.C. § 12132, provides:

"Subject to the provisions of this sub chapter, 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

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of a public entity, *or be subjected to discrimination* by any such entity." (Emphasis added.)

The majority concludes that petitioners "discriminated" against respondents—as a matter of law—by continuing to treat them in an institutional setting after they became eligible for community placement. I disagree. Temporary exclusion from community placement does not amount to "discrimination" in the traditional sense of the word, nor have respondents shown that petitioners "discriminated" against them "by reason of" their disabilities.

Until today, this Court has never endorsed an interpretation of the term "discrimination" that encompassed disparate treatment among members of the *same* protected class. Discrimination, as typically understood, requires a showing that a claimant received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic. This interpretation comports with dictionary definitions of the term discrimination, which means to "distinguish," to "differentiate," or to make a "distinction in favor of or against, a person or thing based on the group, class, or category to which that person or thing belongs rather than on individual merit." Random House Dictionary 564 (2d ed. 1987); see also Webster's Third New International Dictionary 648 (1981) (defining "discrimination" as "the making or perceiving of a distinction or difference" or as "the act, practice, or an instance of discriminating categorically rather than individually").

Our decisions construing various statutory prohibitions against "discrimination" have not wavered from this path. The best place to begin is with Title VII of the Civil Rights Act of 1964, 78 Stat. 253, as amended, the paradigmatic antidiscrimination law.[1] Title VII makes it "an unlawful

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employment practice for an employer . . . to *discriminate* against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin." 42 U.S.C. § 2000e-2(a)(1) (emphasis added). We have explained that this language is designed "to achieve equality of employment opportunities and remove barriers that have operated in the past to favor an identifiable group of white employees over other employees," *Griggs v. Duke Power Co.*, 401 U.S. 424, 429-430 (1971).[2]

Under Title VII, a finding of discrimination requires a comparison of otherwise similarly situated persons who are in different groups by reason of certain characteristics provided by statute. See, *e. g., Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 683 (1983) (explaining

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that Title VII discrimination occurs when an employee is treated " 'in a manner which but for that person's sex would be different' ") (quoting *Los Angeles Dept. of Water and Power v. Manhart*, 435 U.S. 702, 711 (1978)). For this reason, we have described as "nonsensical" the comparison of the racial composition of different classes of job categories in determining whether there existed disparate impact discrimination with respect to a particular job category, *Wards Cove Packing Co. v. Atonio*, 490 U.S. 642, 651 (1989).[3] Courts interpreting Title VII have held that a plaintiff cannot prove "discrimination" by demonstrating that one member of a particular protected group has been favored over another member of that same group. See, *e. g., Bush v. Commonwealth Edison Co.*, 990 F.2d 928, 931 (CA7 1993), cert. denied, 511 U.S. 1071 (1994) (explaining that under Title VII, a fired black employee "had to show that although he was not a good employee, equally bad employees were treated more leniently by [his employer] if they happened not to be black").

Our cases interpreting § 504 of the Rehabilitation Act of 1973, 87 Stat. 394, as amended, which prohibits "discrimination" against certain individuals with disabilities, have applied this commonly understood meaning of discrimination. Section 504 provides:

> "No otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected

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to discrimination under any program or activity receiving Federal financial assistance."

In keeping with the traditional paradigm, we have always limited the application of the term "discrimination" in the Rehabilitation Act to a person who is a member of a protected group and faces discrimination "by reason of his handicap." Indeed, we previously rejected the argument that § 504 requires the type of "affirmative efforts to overcome the disabilities caused by handicaps," *Southeastern Community College v. Davis*, 442 U.S. 397, 410 (1979), that the majority appears to endorse today. Instead, we found that § 504 required merely "the evenhanded treatment of handicapped persons" relative to those persons who do not have disabilities. *Ibid.* Our conclusion was informed by the fact that some provisions of the Rehabilitation Act envision "affirmative action" on behalf of those individuals with disabilities, but § 504 itself "does not refer at all" to such action. *Ibid.* Therefore, "[a] comparison of these provisions demonstrates that Congress understood accommodation of the needs of handicapped individuals may require affirmative action and knew how to provide for it in those instances where it wished to do so." *Id.*, at 411.

Similarly, in *Alexander v. Choate*, 469 U.S. 287, 302 (1985), we found no discrimination under § 504 with respect to a limit on inpatient hospital care that was "neutral on its face" and did not "distinguish between those whose coverage will be reduced and those whose coverage will not on the basis of any test, judgment, or trait that the handicapped as a class are less capable of meeting or less likely of having," *Id.*, at 302. We said that § 504 does "not . . . guarantee the handicapped equal results from the provision of state Medicaid, even assuming some measure of equality of health could be constructed." *Id.*, at 304.

Likewise, in *Traynor v. Turnage*, 485 U.S. 535, 548 (1988), we reiterated that the purpose of § 504 is to guarantee that individuals with disabilities receive "evenhanded treatment"

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relative to those persons without disabilities. In *Traynor*, the Court upheld a Veterans' Administration regulation that excluded "primary alcoholics" from a benefit that was extended to persons disabled by alcoholism related to a mental disorder. *Id.*, at 551. In so doing, the Court noted that "[t]his litigation does not involve a program or activity that is alleged to treat handicapped persons less favorably than non handicapped persons." *Id.*, at 548. Given the theory of the case, the Court explicitly held: "There is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons." *Id.*, at 549.

This same understanding of discrimination also informs this Court's constitutional interpretation of the term. See *General Motors Corp. v. Tracy*, 519 U.S. 278, 298 (1997) (noting with respect to interpreting the Commerce Clause, "[c]onceptually, of course, any notion of discrimination assumes a comparison of substantially similar entities"); *Yick Wo v. Hopkins*, 118 U.S. 356, 374 (1886) (condemning under the Fourteenth Amendment "illegal discriminations between persons in similar circumstances"); see also *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 223-224 (1995); *Richmond v. J. A. Croson Co.*, 488 U.S. 469, 493-494 (1989) (plurality opinion).

Despite this traditional understanding, the majority derives a more "comprehensive" definition of "discrimination," as that term is used in Title II of the ADA, one that includes "institutional isolation of persons with disabilities." *Ante*, at 600. It chiefly relies on certain congressional findings contained within the ADA. To be sure, those findings appear to equate institutional isolation with segregation, and thereby discrimination. See *ibid.* (quoting §§ 12101(a)(2) and 12101(a)(5), both of which explicitly identify "segregation" of persons with disabilities as a form of "discrimination"); see also *ante*, at 588-589. The congressional findings, however, are written in general, hortatory terms and

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provide little guidance to the interpretation of the specific language of § 12132. See *National Organization for Women, Inc. v. Scheidler*, 510 U.S. 249, 260 (1994) ("We also think that the quoted statement of congressional findings is a rather thin reed upon which to base a requirement"). In my view, the vague congressional findings upon which the majority relies simply do not suffice to show that Congress sought to overturn a well-established understanding of a statutory term (here, "discrimination").[4] Moreover, the majority fails to explain why terms in the findings should be given a medical content, pertaining to the place where a mentally retarded person is treated. When read in context, the findings instead suggest that terms such as "segregation" were used in a more general sense, pertaining to matters such as access to employment, facilities, and transportation. Absent a clear directive to the contrary, we must read "discrimination" in light of the common understanding of the term. We cannot expand the meaning of the term "discrimination" in order to invalidate policies we may find unfortunate. Cf. *NLRB v. Highland Park Mfg. Co.*, 341 U.S. 322, 325 (1951) (explaining that if Congress intended statutory terms "to have other than their ordinarily accepted meaning,

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it would and should have given them a special meaning by definition").[6]

Elsewhere in the ADA, Congress chose to alter the traditional definition of discrimination. Title I of the ADA, § 12112(b)(1), defines discrimination to include "limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee." Notably, however, Congress did not provide that this definition of discrimination, unlike other aspects of the ADA, applies to Title II. Ordinary canons of construction require that we respect the limited applicability of this definition of "discrimination" and not import it into other parts of the law where Congress did not see fit. See, *e. g., Bates v. United States,* 522 U.S. 23, 29-30 (1997) (" 'Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion' ") (quoting *Russello v. United States,* 464 U.S. 16, 23 (1983)). The majority's definition of discrimination—although not specifically delineated—substantially imports the definition of Title I into Title II by necessarily assuming that it is sufficient to focus exclusively on members of one particular

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group. Under this view, discrimination occurs when some members of a protected group are treated differently from other members of that same group. As the preceding discussion emphasizes, absent a special definition supplied by Congress, this conclusion is a remarkable and novel proposition that finds no support in our decisions in analogous areas. For example, the majority's conclusion that petitioners "discriminated" against respondents is the equivalent to finding discrimination under Title VII where a black employee with deficient management skills is denied in-house training by his employer (allegedly because of lack of funding) because other similarly situated black employees are given the in-house training. Such a claim would fly in the face of our prior case law, which requires more than the assertion that a person belongs to a protected group and did not receive some benefit. See, *e. g., Griggs,* 401 U.S., at 430-431 ("Congress did not intend by Title VII, however, to guarantee a job to every person regardless of qualifications. In short, the Act does not command that any person be hired simply because he was formerly the subject of discrimination, or because he is a member of a minority group").

At bottom, the type of claim approved of by the majority does not concern a prohibition against certain conduct (the traditional understanding of discrimination), but rather concerns imposition of a standard of care.[6] As such, the majority

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can offer no principle limiting this new species of "discrimination" claim apart from an affirmative defense because it looks merely to an individual in isolation, without comparing him to otherwise similarly situated persons, and determines that discrimination occurs merely because that individual does not receive the treatment he wishes to receive. By adopting such a broad view of discrimination, the majority drains the term of any meaning other than as a proxy for decisions disapproved of by this Court.

Further, I fear that the majority's approach imposes significant federalism costs, directing States how to make decisions about their delivery of public services. We previously have recognized that constitutional principles of

federalism erect limits on the Federal Government's ability to direct state officers or to interfere with the functions of state governments. See, *e. g., Printz v. United States*, 521 U.S. 898 (1997); *New York v. United* States, 505 U.S. 144 (1992). We have suggested that these principles specifically apply to whether States are required to provide a certain level of benefits to individuals with disabilities. As noted in *Alexander*, in rejecting a similar theory under § 504 of the Rehabilitation Act: "[N]othing . . . suggests that Congress desired to make major inroads on the States' long standing discretion to choose the proper mix of amount, scope, and duration limitations on services . . . ." 469 U.S., at 307. See also *Bowen v. American Hospital Assn.*, 476 U.S. 610, 642 (1986) (plurality opinion) ("[N]othing in [§ 504] authorizes [the Secretary of Health and Human Services (HHS)] to commandeer state agencies . . . . [These] agencies are

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not field offices of the HHS bureaucracy, and they may not be conscripted against their will as the foot soldiers in a federal crusade"). The majority's affirmative defense will likely come as cold comfort to the States that will now be forced to defend themselves in federal court every time resources prevent the immediate placement of a qualified individual. In keeping with our traditional deference in this area, see *Alexander, supra*, the appropriate course would be to respect the States' historical role as the dominant authority responsible for providing services to individuals with disabilities.

The majority may remark that it actually does properly compare members of different groups. Indeed, the majority mentions in passing the "[d]is similar treatment" of persons with and without disabilities. *Ante*, at 601. It does so in the context of supporting its conclusion that institutional isolation is a form of discrimination. It cites two cases as standing for the unremarkable proposition that discrimination leads to deleterious stereotyping, *ante*, at 600 (citing *Allen v. Wright*, 468 U.S. 737, 755 (1984); *Manhart*, 435 U.S., at 707, n. 13)), and an *amicus* brief which indicates that confinement diminishes certain everyday life activities, *ante*, at 601 (citing Brief for American Psychiatric Association et al. as *Amici Curiae* 20-22). The majority then observes that persons without disabilities "can receive the services they need without" institutionalization and thereby avoid these twin deleterious effects. *Ante*, at 601. I do not quarrel with the two general propositions, but I fail to see how they assist in resolving the issue before the Court. Further, the majority neither specifies what services persons with disabilities might need nor contends that persons without disabilities need the same services as those with disabilities, leading to the inference that the dissimilar treatment the majority observes results merely from the fact that different classes of persons receive different services—not from "discrimination" as traditionally defined.

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Finally, it is also clear petitioners did not "discriminate" against respondents "by reason of [their] disabili [ties]," as § 12132 requires. We have previously interpreted the phrase "by reason of" as requiring proximate causation. See, *e. g., Holmes v. Securities Investor Protection Corporation*, 503 U.S. 258, 265-266 (1992); see also *id.*, at 266, n. 11 (citation of cases). Such an interpretation is in keeping with the vernacular understanding of the phrase. See American Heritage Dictionary 1506 (3d ed. 1992) (defining "by reason of" as "because of"). This statute should be read as requiring proximate causation as well. Respondents do not contend that their disabilities constituted the proximate cause for their exclusion. Nor could they—community placement simply is not available to

those without disabilities. Continued institutional treatment of persons who, though now deemed treatable in a community placement, must wait their turn for placement does not establish that the denial of community placement occurred "by reason of" their disability. Rather, it establishes no more than the fact that petitioners have limited resources.

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For the foregoing reasons, I respectfully dissent.

Notes:

[*] Briefs of *amici curiae* urging reversal were filed for the State of Nevada et al. by *Frankie Sue Del Papa*, Attorney General of Nevada, and *Anne B. Cathcart*, Special Assistant Attorney General, *Mike Moore*, Attorney General of Mississippi, and *Robert E. Sanders*, Assistant Attorney General, *John Cornyn*, Attorney General of Texas, *Andy Taylor*, First Assistant Attorney General, *Linda S. Eads*, Deputy Attorney General, and *Gregory S. Coleman*, Solicitor General, and by the Attorneys General for their respective States as follows: *Ken L. Salazar* of Colorado, *Jeffrey A. Modisett* of Indiana, *Margery S. Bronster* of Hawaii, *Richard P. Ieyoub* of Louisiana, *Thomas F. Reilly* of Massachusetts, *Joseph P. Mazurek* of Montana, *Charles M. Condon* of South Carolina, *Paul G. Summers* of Tennessee, *Christine O. Gregoire* of Washington, and *Gay Woodhouse* of Wyoming; and for the National Conference of State Legislatures et al. by *Richard Ruda* and *James I. Crowley*.

Briefs of *amici curiae* urging affirmance were filed for the American Association on Mental Retardation et al. by *Alan M. Wiseman*, *Timothy K. Armstrong*, and *Ira A. Burnim*; for the American Civil Liberties Union et al. by *Laurie Webb Daniel* and *Steven R. Shapiro*; for the American Psychiatric Association et al. by *Richard G. Taranto*; for 58 Former State Commissioners and Directors of Mental Health and Developmental Disabilities et al. by *Neil V. McKittrick*; for the National Council on Disability by *Robert L. Burgdorf, Jr.*; for the National Mental Health Consumers' Self-Help Clearinghouse et al. by *Loralyn McKinley*; for Dick Thornburgh et al. by *Mr. Thornburgh, pro se*, *James E. Day*, and *David R. Fine*; for People First of Georgia et al. by *Thomas K. Gilhool*; and for the Voice of the Retarded et al. by *William J. Burke* and *Tamie Hopp*.

Stephen F. Gold filed a brief for ADAPT et al. as *amici curiae*.

[1] The ADA, enacted in 1990, is the Federal Government's most recent and extensive endeavor to address discrimination against persons with disabilities. Earlier legislative efforts included the Rehabilitation Act of 1973, 87 Stat. 355, 29 U.S.C. § 701 *et seq.* (1976 ed.), and the Developmentally Disabled Assistance and Bill of Rights Act, 89 Stat. 486, 42 U.S.C. § 6001 *et seq.* (1976 ed.), enacted in 1975. In the ADA, Congress for the first time referred expressly to "segregation" of persons with disabilities as a "for[m] of discrimination," and to discrimination that persists in the area of "institutionalization." §§ 12101(a)(2), (3), (5).

[2] The ADA defines "disability," "with respect to an individual," as

"(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

"(B) a record of such an impairment; or

"(C) being regarded as having such an impairment." § 12102(2).

There is no dispute that L. C. and E. W. are disabled within the meaning of the ADA.

[3] In addition to the provisions set out in Part A governing public services generally, see §§ 12131-12134, Title II contains in Part B a host of provisions governing public transportation services, see §§ 12141-12165.

[4] Section 505 of the Rehabilitation Act incorporates the remedies, rights, and procedures set forth in Title VI of the Civil Rights Act of 1964 for violations of § 504 of the Rehabilitation Act. See 29 U.S.C. § 794a(a)(2). Title VI, in turn, directs each federal department authorized to extend financial assistance to any department or agency of a State to issue rules and regulations consistent with achievement of the objectives of the statute authorizing financial assistance. See 78 Stat. 252, 42 U.S.C. § 2000d-1. Compliance with such requirements may be effected by the termination or denial of federal funds, or "by any other means authorized by law." *Ibid.* Remedies both at law and in equity are available for violations of the statute. See § 2000d-7(a)(2).

[5] Congress directed the Secretary of Transportation to issue regulations implementing the portion of Title II concerning public transportation. See 42 U.S.C. §§ 12143(b), 12149, 12164. As stated in the regulations, a person alleging discrimination on the basis of disability in violation of Title II may seek to enforce its provisions by commencing a private lawsuit, or by filing a complaint with (a) a federal agency that provides funding to the public entity that is the subject of the complaint, (b) the Department of Justice for referral to an appropriate agency, or (c) one of eight federal agencies responsible for investigating complaints arising under Title II: the Department of Agriculture, the Department of Education, the Department of Health and Human Services, the Department of Housing and Urban Development, the Department of the Interior, the Department of Justice, the Department of Labor, and the Department of Transportation. See 28 CFR §§ 35.170(c), 35.172(b), 35.190(b) (1998).

The ADA contains several other provisions allocating regulatory and enforcement responsibility. Congress instructed the Equal Employment Opportunity Commission (EEOC) to issue regulations implementing Title I; see 42 U.S.C. § 12116; the EEOC, the Attorney General, and persons alleging discrimination on the basis of disability in violation of Title I may enforce its provisions, see § 12117(a). Congress similarly instructed the Secretary of Transportation and the Attorney General to issue regulations implementing provisions of Title III, see §§ 12186(a)(1), (b); the Attorney General and persons alleging discrimination on the basis of disability in violation of Title III may enforce its provisions, see §§ 12188(a)(1), (b). Each federal agency responsible for ADA implementation may render technical assistance to affected individuals and institutions with respect to provisions of the ADA for which the agency has responsibility. See § 12206(c)(1).

[6] L. C. and E. W. are currently receiving treatment in community-based programs. Nevertheless, the case is not moot. As the District Court and Court of Appeals explained, in view of the multiple institutional placements L. C. and E. W. have experienced, the controversy they brought to court is "capable of repetition, yet evading review." No. 1:95-cv-1210 -MHS (ND Ga., Mar. 26, 1997), p. 6, App. to Pet. for Cert. 35a (internal quotation marks omitted); see 138 F.3d 893, 895, n. 2 (CA11 1998) (citing *Honig v. Doe*, 484 U.S. 305, 318-323 (1988), and *Vitek v. Jones*, 445 U.S. 480, 486-487 (1980)).

[7] After this Court granted certiorari, the District Court issued a decision on remand rejecting the State's fundamental-alteration defense. See 1:95-cv-1210-MHS (ND Ga., Jan. 29, 1999), p. 1. The court concluded that the annual cost to the State of providing community-based treatment to L. C. and E. W. was not unreasonable in relation to the State's overall mental health budget. See *id.*, at 5. In reaching that judgment, the District Court first declared "irrelevant" the potential impact of its decision beyond L. C. and E. W. 1:95-cv-1210-MHS (ND Ga., Oct. 20, 1998), p. 3, App. 177. The District Court's decision on remand is now pending appeal before the Eleventh Circuit.

[8] Twenty-two States and the Territory of Guam joined a brief urging that certiorari be granted. Ten of those States joined a brief in support of petitioners on the merits.

[9] See Brief for United States in *Halderman v. Pennhurst State School and Hospital*, Nos. 78-1490, 78-1564, 78-1602 (CA3 1978), p. 45 ("[I]nstitutionalization result[ing] in separation of mentally retarded persons for no permissible reason . . . is 'discrimination,' and a violation

of Section 504 [of the Rehabilitation Act] if it is supported by federal funds."); Brief for United States in *Helderman v. Pennhurst State School and Hospital*, Nos. 78-1490, 78-1664, 78-1602 (CA3 1981), p. 27 ("Pennsylvania violates Section 504 by indiscriminately subjecting handicapped persons to [an institution] without first making an individual reasoned professional judgment as to the appropriate placement for each such person among all available alternatives."); Brief for United States as *Amicus Curiae* in *Helen L. v. DiDario*, No. 94-1243 (CA3 1994), p. 7 ("Both the Section 504 coordination regulations and the rest of the ADA make clear that the unnecessary segregation of individuals with disabilities in the provision of public services is itself a form of discrimination within the meaning of those statutes."); *id.*, at 8-16.

[10] The dissent is driven by the notion that "this Court has never endorsed an interpretation of the term 'discrimination' that encompassed disparate treatment among members of the *same* protected class," *post*, at 616 (opinion of Thomas, J.), that "[o]ur decisions construing various statutory prohibitions against 'discrimination' have not wavered from this path," *post*, at 616, and that "a plaintiff cannot prove 'discrimination' by demonstrating that one member of a particular protected group has been favored over another member of that same group," *post*, at 618. The dissent is incorrect as a matter of precedent and logic. See *O'Connor v. Consolidated Coin Caterers Corp.*, 517 U.S. 308, 312 (1996) (The Age Discrimination in Employment Act of 1967 "does not ban discrimination against employees because they are aged 40 or older; it bans discrimination against employees because of their age, but limits the protected class to those who are 40 or older. The fact that one person in the protected class has lost out to another person in the protected class is thus irrelevant, so long as he has lost out *because of his age*."); cf. *Oncale v. Sundowner Offshore Services, Inc.*, 523 U.S. 75, 76 (1998) ("[W]orkplace harassment can violate Title VII's prohibition against 'discriminat[ion] . . . because of . . . sex,' 42 U.S.C. § 2000e-2(a)(1), when the harasser and the harassed employee are of the same sex."); *Jefferies v. Harris County Community Action Assn.*, 615 F.2d 1025, 1032 (CA5 1980) ("[D]iscrimination against black females can exist even in the absence of discrimination against black men or white women.").

[11] Unlike the ADA, § 504 of the Rehabilitation Act contains no express recognition that isolation or segregation of persons with disabilities is a form of discrimination. Section 504's discrimination proscription, a single sentence attached to vocational rehabilitation legislation, has yielded divergent court interpretations. See Brief for United States as *Amicus Curiae* 23-25.

[12] The waiver program provides Medicaid reimbursement to States for the provision of community-based services to individuals who would otherwise require institutional care, upon a showing that the average annual cost of such services is not more than the annual cost of institutional services. See § 1396n(c).

[13] Georgia law also expresses a preference for treatment in the most integrated setting appropriate. See Ga. Code Ann. § 37-4-121 (1995) ("It is the policy of the state that the least restrictive alternative placement be secured for every client at every stage of his habilitation. It shall be the duty of the facility to assist the client in securing placement in non-institutional community facilities and programs.").

[14] We do not in this opinion hold that the ADA imposes on the States a "standard of care" for whatever medical services they render, or that the ADA requires States to "provide a certain level of benefits to individuals with disabilities." Cf. *post*, at 623, 624 (Thomas, J., dissenting). We do hold, however, that States must adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide.

[15] Even if States eventually were able to close some institutions in response to an increase in the number of community placements, the States would still incur the cost of running partially full institutions in the interim. See Brief for United States as *Amicus Curiae* 21.

[16] We reject the Court of Appeals' construction of the reasonable-modifications regulation for another reason. The Attorney General's Title II regulations, Congress ordered, "shall be consistent with" the regulations in part 41 of Title 28 of the Code of Federal Regulations implementing § 504 of the Rehabilitation Act. 42 U.S.C. § 12134(b). The § 504 regulation upon which the reasonable-modifications regulation is based provides now, as it did at the time the ADA was enacted:

"A recipient shall make reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate that the accommodation would impose an undue hardship on the operation of its program." 28 CFR § 41.53 (1990 and 1998 eds.).

While the part 41 regulations do not define "undue hardship," other § 504 regulations make clear that the "undue hardship" inquiry requires not simply an assessment of the cost of the accommodation in relation to the recipient's overall budget, but a "case-by-case analysis weighing factors that include: (1) [t]he overall size of the recipient's program with respect to number of employees, number and type of facilities, and size of budget; (2) [t]he type of the recipient's operation, including the composition and structure of the recipient's workforce; and (3) [t]he nature and cost of the accommodation needed." 28 CFR § 42.511(c) (1998); see 45 CFR § 84.12(c) (1998) (same).

Under the Court of Appeals' restrictive reading, the reasonable-modifications regulation would impose a standard substantially more difficult for the State to meet than the "undue burden" standard imposed by the corresponding § 504 regulation.

[1] We have incorporated Title VII standards of discrimination when interpreting statutes prohibiting other forms of discrimination. For example, Rev. Stat. § 1977, as amended, 42 U.S.C. § 1981, has been interpreted to forbid all racial discrimination in the making of private and public contracts. See *Saint Francis College v. Al-Khazraji*, 481 U.S. 604, 609 (1987). This Court has applied the "framework" developed in Title VII cases to claims brought under this statute. *Patterson v. McLean Credit Union*, 491 U.S. 164, 186 (1989). Also, the Age Discrimination in Employment Act of 1967, 81 Stat. 602, as amended, 29 U.S.C. § 623(a)(1), prohibits discrimination on the basis of an employee's age. This Court has noted that its "interpretation of Title VII . . . applies with equal force in the context of age discrimination, for the substantive provisions of the ADEA 'were derived *in haec verba* from Title VII.' " *Trans World Airlines, Inc. v. Thurston*, 469 U.S. 111, 121 (1985) (quoting *Lorillard v. Pons*, 434 U.S. 575, 584 (1978)). This Court has also looked to its Title VII interpretations of discrimination in illuminating Title IX of the Education Amendments of 1972, 86 Stat. 373, as amended, 20 U.S.C. § 1681 *et seq.*, which prohibits discrimination under any federally funded education program or activity. See *Franklin v. Gwinnett County Public Schools*, 503 U.S. 60, 75 (1992) (relying on *Meritor Savings Bank, FSB v. Vinson*, 477 U.S. 57 (1986), a Title VII case, in determining that sexual harassment constitutes discrimination).

[2] This Court has recognized that two forms of discrimination are prohibited under Title VII: disparate treatment and disparate impact. See *Griggs*, 401 U.S., at 431 ("The Act proscribes not only overt discrimination but also practices that are fair in form, but discriminatory in operation"). Both forms of "discrimination" require a comparison among classes of employees.

[3] Following *Wards Cove*, Congress enacted the Civil Rights Act of 1991, Pub. L. 102-166, 105 Stat. 1071, as amended, which, *inter alia*, altered the burden of proof with respect to a disparate impact discrimination claim. See *id.*, § 105 (codified at 42 U.S.C. § 2000e-2(k)). This change highlights the principle that a departure from the traditional understanding of discrimination requires congressional action. Cf. *Field v. Mans*, 516 U.S. 59, 69-70 (1995) (Congress legislates against the background rule of the common law and traditional notions of lawful conduct).

[4] If such general hortatory language is sufficient, it is puzzling that this or any other court did not reach the same conclusion long ago by reference to the general purpose language of the Rehabilitation Act itself. See 29 U.S.C. § 701 (1988 ed.) (describing the statute's purpose as "to develop and implement, through research, training, services, and the guarantee of equal opportunity, comprehensive and coordinated programs of vocational rehabilitation and independent living, for individuals with handicaps *in order to maximize their employability, independence, and integration* into the workplace and the community" (emphasis added)). Further, this section has since been amended to proclaim in even more aspirational terms that the policy under the statute is driven by, *inter alia*, "respect for individual dignity, personal responsibility, self-determination, and pursuit of meaningful careers, based on informed choice, of individuals with disabilities," "respect for the privacy, rights, and equal access," and "inclusion, integration, and full participation of the individuals." 29 U.S.C. §§ 701(c)(1)-(3).

[5] Given my conclusion, the Court need not review the integration regulation promulgated by the Attorney General. See 28 CFR §

35.130(d)(1998). Deference to a regulation is appropriate only "'if Congress has not expressed its intent with respect to the question, and then only if the administrative interpretation is reasonable.' " *Reno v. Bossier Parish School Bd.*, 520 U.S. 471, 483 (1997) (quoting *Presley v. Etowah County Comm'n*, 502 U.S. 491, 508 (1992)). Here, Congress has expressed its intent in § 12132, and the Attorney General's regulation—insofar as it contradicts the settled meaning of the statutory term—cannot prevail against it. See *NLRB v. Town & Country Elec., Inc.*, 516 U.S. 85, 94(1995) (explaining that courts interpreting a term within a statute "must infer, unless the statute otherwise dictates, that Congress means to incorporate the established meaning of that term" (internal quotation marks omitted)).

[6] In mandating that government agencies minimize the institutional isolation of disabled individuals, the majority appears to appropriate the concept of "mainstreaming" from the Individuals with Disabilities Education Act (IDEA), 84 Stat. 175, as amended, 20 U.S.C.§ 1400 *et seq.* But IDEA is not an antidiscrimination law. It is a grant program that affirmatively requires States accepting federal funds to provide disabled children with a "free appropriate public education" and to establish "procedures to assure that, to the maximum extent appropriate, children with disabilities . . . are educated with children who are not disabled." §§ 1412(1), (5). Ironically, even under this broad affirmative mandate, we previously rejected a claim that IDEA required the "standard of care" analysis adopted by the majority today. See *Board of Ed. of Hendrick Hudson Central School Dist., Westchester Cty. v. Rowley*, 458 U.S. 176, 198 (1982) ("We think . . . that the requirement that a State provide specialized educational services to handicapped children generates no additional requirement that the services so provided be sufficient to maximize each child's potential commensurate with the opportunity provided other children" (internal quotation marks omitted)).

FindLaw FOR LEGAL PROFESSIONALS

United States Court of Appeals, Ninth Circuit.

BARKER v. RIVERSIDE COUNTY OFFICE OF EDUCATION

Susan Lee BARKER, Plaintiff-Appellant, v. RIVERSIDE COUNTY OFFICE OF EDUCATION, Defendant-Appellee.

No. 07-56313.

Argued and Submitted Dec. 12, 2008. -- October 23, 2009

Before: HARRY PREGERSON and D.W. NELSON, Circuit Judges, and JAMES K. SINGLETON, Senior District Judge.*

Janice S. Cleveland, Law offices of Janice S. Cleveland, Riverside, CA, and Gary S. Bennett, Law Offices of Gary S. Bennett, Laguna Hills, CA, for the plaintiff-appellant. Jennifer D. Cantrell and Mark W. Thompson, Atkinson, Andelson, Loya, Ruud & Romo, Riverside, CA, for the defendant-appellee.

Susan Lee Barker was employed by the Riverside County Office of Education as a Resource Specialist Program teacher for students with disabilities. She brought suit against her employer based on constructive termination arising out of an intolerable work environment. Barker's complaint alleged that her supervisors at the Riverside County Office of Education retaliated against her after she voiced concerns that the Riverside County Office of Education was not complying with requirements of federal and state law in how it provided educational services to its disabled students. The district court dismissed Barker's lawsuit for lack of standing. Barker argues that she has standing to sue the Riverside County Office of Education pursuant to the anti-retaliation provisions of both section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act ("ADA"). We agree with Barker and therefore reverse and remand.

I. Background

Barker was employed as an itinerant Resource Specialist Program teacher for students with disabilities within the Alternative Education Program of the Riverside County Office of Education from May 13, 2002 through August 1, 2006. Indeed, Barker was the most experienced special education teacher at the Riverside County Office of Education. Barker was regularly asked by other teachers to interpret educational test results, and she

received three or four telephone calls per day from her colleagues requesting her opinion and assistance in regard to special education issues with students.

Beginning as early as 2003, Barker voiced concerns to her supervisors that the special education services provided by the Riverside County Office of Education to its disabled students were noncompliant with federal and state law. In May 2005, Barker and a coworker filed a class discrimination complaint with the U.S. Department of Education's Office for Civil Rights. The class discrimination complaint filed with the Office for Civil Rights alleged that the Riverside County Office of Education denied its disabled students a free appropriate public education that they are entitled to receive under federal and state law.

In June 2005, Barker's supervisors at the Riverside County Office of Education first learned that Barker filed the class discrimination complaint with the U.S. Department of Education's Office for Civil Rights. In the constructive termination action now before us, Barker alleges that her supervisors then retaliated against her throughout the following school year by

1. intimidating Barker for filing the class discrimination complaint with the Office for Civil Rights;

2. failing to respond to Barker's emails and phone calls;

3. excluding Barker from important staff meetings;

4. changing Barker's work assignments to sites further from her home;

5. reducing Barker's caseload even though the Riverside County Office of Education's Alternative Education's disabled student population increased; and

6. refusing to allow Barker to fill in for other teachers during their vacations.

Barker further alleged that she was constructively terminated on August 1, 2006 because her supervisors subjected her to an intolerable work environment.

On July 13, 2005, Barker submitted a written complaint to the U.S. Department of Education's Office for Civil Rights, alleging that the Riverside County Office of Education retaliated against her for advocating on behalf of her students with disabilities and for filing a complaint with the Office for Civil Rights. The Office for Civil Rights subsequently conducted an investigation into Barker's complaint by gathering evidence through interviews with Barker and fifteen current and former Riverside County Office of Education staff and administrators, and reviewing documents and records submitted by Barker and the Riverside County Office of Education.

On June 16, 2006, the Office for Civil Rights determined that the "preponderance of the evidence showed that [the Riverside County Office of Education] retaliated against

[Barker] in violation of Section 504[and] Title II." The Office for Civil Rights further stated that "[a]dvocacy on behalf of disabled students on issues related to their civil rights, and the filing of [Office for Civil Rights] complaints, are protected activities under Section 504 and Title II."

Barker then filed a complaint in federal district court contending that the Riverside County Office of Education violated the anti-retaliation provisions of both § 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act by retaliating against her after she advocated on behalf of her students with disabilities. In August 2007, following the Riverside County Office of Education's Fed.R.Civ.P. 12(b)(6) motion, the district court found that Barker did not have standing to sue under either statute and dismissed her claim with prejudice. Barker timely appealed.

II. Standard of Review

The district court's dismissal of an action pursuant to Fed.R.Civ.P. 12(b)(6) is reviewed de novo. Zimmerman v. Or. Dep't of Justice, 170 F.3d 1169, 1172 (9th Cir.1999). "Because this is an appeal from the dismissal of an action pursuant to Fed. R.Civ. P. 12(b)(6), we accept as true the facts alleged in the complaint." Id. at 1171. Moreover, we must draw inferences in the light most favorable to the plaintiff. See Scheuer v. Rhodes, 416 U.S. 232, 236, 94 S.Ct. 1683, 40 L.Ed.2d 90 (1974).

III. Discussion

A. Section 504 of the Rehabilitation Act of 1973

Barker contends that she has standing[1] to sue her employer, the Riverside County Office of Education, for retaliating against her pursuant to section 504 of the Rehabilitation Act. She argues that section 504 grants standing to individuals who are retaliated against for attempting to protect the rights of disabled people, even if they themselves are not disabled. The Riverside County Office of Education, however, argues that because Barker failed to allege that she was a "qualified individual with a disability," see 29 U.S.C. § 794(a), she cannot avail herself of the Rehabilitation Act's protection against retaliation. According to the Riverside County Office of Education, Section 504 was not "intended to provide redress of employment claims for persons who [are] neither disabled themselves, nor have any close relationship to a disabled person." Contrary to the Riverside County Office of Education's arguments, we find that the anti-retaliation provision of section 504 grants standing to non-disabled people who are retaliated against for attempting to protect the rights of the disabled.

In determining whether Barker has standing under section 504, we begin by examining the statute's plain meaning. See Molski v. M.J. Cable, Inc., 481 F.3d 724, 732 (9th Cir.2007). When "the statutory language is clear and consistent with the statutory scheme at issue, the plain language of the statute is conclusive and the judicial inquiry is at an end." Id. Section 504(a) states:

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 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).[2] The anti-retaliation provision of Title VI of the Civil Rights Act incorporated by section 504 states:

No recipient or other person shall intimidate, threaten, coerce, or discriminate against any individual for the purpose of interfering with any right or privilege secured by Section 601 of [the Civil Rights] Act or this part, or because he has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under this part.

34 C.F.R. § 100.7(e) (emphasis added). This regulation applies to all rights secured by the Rehabilitation Act pursuant to 34 C.F.R. § 104.61. In other words, 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' 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, 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).

Contrary to the Riverside County Office of Education's arguments, the broad statutory language in section 504 and its corresponding anti-retaliation provision in Title VI of the Civil Rights Act does not demonstrate that Congress intended to limit standing under section 504 to only those with disabilities.[3] Section 504 and its anti-retaliation provision use the all-inclusive phrases "any person aggrieved" and "any individual," and no language further limits who "any person aggrieved" or "any individual" may be. In particular, the statutes do not include language requiring such individuals to have disabilities in order to have standing. Nor do they require the protected individual to have any "close relationship to a disabled person," as argued by the Riverside County Office of Education. Indeed, the use of "such broad language" in the statutes "evinces a congressional intention to define standing to bring a private action under 504 . as broadly as is permitted by Article III of the Constitution." Innovative Health Sys., Inc. v. City of White Plains, 117 F.3d 37, 47 (2nd Cir.1997) (internal quotation marks omitted) (citing Trafficante v. Metropolitan Life Ins. Co., 409 U.S. 205, 209, 93 S.Ct. 364, 34 L.Ed.2d 415 (1972) (holding that the term "aggrieved person" in section 810(a) of the Fair Housing Act

demonstrated Congress's "intention to define standing as broadly as is permitted by Article III of the Constitution")) (holding that a drug and alcohol rehabilitation center had standing pursuant to section 504 of the Rehabilitation Act to sue a city for discriminatory motives in denying a building permit).

Such reasoning is consistent with Congress's statutory goal to protect the rights of the disabled. While "Congress could have limited the remedial provisions of the Rehabilitation Act to claims brought by or on behalf of disabled individuals, it did not do so in apparent recognition of the fact that disabled individuals may need assistance in vindicating their rights." Weber, 212 F.3d at 49. Indeed, empathetic people who teach and interact frequently with the disabled are those most likely to recognize their mistreatment and to advocate on their behalf.

Furthermore, while not controlling authority, it is persuasive that after completing an investigation into Barker's complaint, the Department of Education's Office for Civil Rights concluded that "[a]dvocacy on behalf of disabled students on issues related to their civil rights, and the filing of [Office for Civil Rights] complaints, are protected activities under Section 504 and Title II." [4] See Skidmore v. Swift & Co., 323 U.S. 134, 140, 65 S.Ct. 161, 89 L.Ed. 124 (1944) (holding that "while[non-binding agency opinions are] not controlling upon the courts by reason of their authority, [these opinions] do constitute a body of experience . that give [them] power to persuade, if lacking power to control"); see also Garcia-Quintero v. Gonzales, 455 F.3d 1006, 1014 (9th Cir.2006).

Accordingly, we find that the district court erred in its determination that Barker lacked standing under section 504, and we reverse.

B. Title II of the Americans with Disabilities Act

Barker contends that she also has standing to sue the Riverside County Office of Education under Title II of the Americans with Disabilities Act ("ADA"). Again, the Riverside County Office of Education alleges that Barker does not have standing to sue under Title II because Barker is not a "qualified individual with a disability." See 42 U.S.C. § 12132. We find that Barker does have standing under Title II for the same reasons that she has standing under section 504 of the Rehabilitation Act. Cf. Innovative Health Sys., 117 F.3d at 46-48 (holding that a drug and alcohol rehabilitation center had standing to sue the city of White Plains for its discriminatory motives in denying the center a building permit under Title II of the ADA).

We begin by examining whether the plain meaning of the language used in Title II of the ADA and its anti-retaliation provisions grant standing to non-disabled individuals who are retaliated against for attempting to protect the rights of the disabled. See Molski, 481 F.3d at 732. Title II of the ADA provides:

Subject to the provisions of this subchapter, 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 provisions of Title II of the ADA state:

(a) No private or public entity shall discriminate against any individual because that individual has opposed any act or practice made unlawful by this part, or because that individual made a charge, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under the Act or this part.

(b) No private or public entity shall coerce, intimidate, threaten, or interfere with any individual in the exercise or enjoyment of, or on account of his or her having exercised or enjoyed, or on account of his or her having aided or encouraged any other individual in the exercise or enjoyment of, any right granted or protected by the Act or this part.

28 C.F.R. § 35.134 (emphasis added). As in our analysis of section 504 of the Rehabilitation Act, the language employed in the anti-retaliation provisions of Title II does not evince a congressional intent to limit standing to individuals with disabilities. Instead, the use of the phrase "any individual" and the absence of any language limiting standing to those with disabilities indicates Congress's intent to grant standing under Title II "as broadly as is permitted by Article III of the Constitution." See Innovative Health Sys., 117 F.3d at 47 (citing Trafficante v. Metropolitan Life Ins., Co., 409 U.S. 205, 209, 93 S.Ct. 364, 34 L.Ed.2d 415(1972)). As we recognized in our Rehabilitation Act analysis, it appears that in formulating the language in Title II's anti-retaliation provisions, Congress recognized that disabled individuals may require assistance from others to defend their rights. Cf. Weber, 212 F.3d at 49 (While "Congress could have limited the remedial provisions of [Title II] to claims brought by or on behalf of disabled individuals, it did not do so in apparent recognition of the fact that disabled individuals may need assistance in vindicating their rights.").

Indeed, we find that the language of Title II's anti-retaliation provisions set forth in 28 C.F.R. § 35.134 grants standing to Barker. Clause (a) of § 35.134 protects "any individual" who "has opposed any act or practice made unlawful by this part." 28 C.F.R. § 35.134 (emphasis added). Because Barker engaged in activities opposing her school's special education policies that allegedly violated the ADA, we find that she had standing to pursue her claim under clause (a). Furthermore, clause (b) protects "any individual" from being "coerce[d], intimidate[d], threaten[ed], or interfere[d] with" by a "public entity" "on account of . her having aided or encouraged any other individual in the exercise or enjoyment of, any right granted or protected by the Act." Id. (emphasis added). Because Barker alleges that she was intimidated by her supervisor for her role in advocating for her students, we find that Barker also has standing under clause (b) of Title II's anti-retaliation provision.

The district court's reliance on Zimmerman v. Oregon Department of Justice, 170 F.3d 1169 (9th Cir.1999) in determining that Barker lacked standing under Title II of the ADA was misguided. In Zimmerman, the plaintiff alleged that he was fired from his job

because of his visual impairment in violation of Title II of the ADA. Id. at 1171. We held in Zimmerman that the plaintiff's claim should have been brought under Title I of the ADA instead of under Title II, because the plaintiff claimed that his employer discriminated against him because he had a disability, and employment violations are protected under "Title I: Employment." Id. at 1178. Here, relying on Zimmerman, the district court incorrectly found that because Barker also claimed that she was discriminated against by her employer, Barker would similarly only have standing under Title I of the ADA.

Contrary to the district court's finding, Barker's situation can easily be distinguished from that in Zimmerman. Unlike Zimmerman, Barker does not allege that she lost her job because her employer discriminated against her because of a disability she had. Instead, Barker alleges that she was retaliated against and subsequently lost her job because she advocated for disabled students who were receiving inadequate public services-educational services provided by a public school-which are covered under Title II of the ADA ("Title II: Public Services"). See 42 U.S.C. § 12131, et seq. Public services provided to disabled students are the focus of Title II of the ADA. See id. Thus, Barker's claim was appropriately brought under Title II. Accordingly, the district court erred in determining that our holding in Zimmerman "compell[ed] a conclusion contrary to that reached by the Weber court."[2] Instead, our finding that Barker has standing to bring a claim against the Riverside County Office of Education under Title II of the ADA is consistent with our holding in Zimmerman.

IV. Conclusion

Having concluded that Barker has standing to pursue her retaliation claims under both section 504 of the Rehabilitation Act and Title II of the ADA, we reverse and remand to the district court.

REVERSED and REMANDED.

FOOTNOTES

1. Although Barker's standing to sue the Riverside County Office of Education pursuant to the Rehabilitation Act and the ADA is under review in this case, Barker unquestionably meets the constitutional standing requirements of Article III. See Valley Forge Christian Coll. v. Am. United for Separation of Church & State, Inc., 454 U.S. 464, 472, 102 S.Ct. 752, 70 L.Ed.2d 700 (1982). First, Barker alleges an actual injury-that she was constructively terminated from her job as a special education teacher with the Riverside County Office of Education. See id. Second, Barker's injury "fairly can be traced to the challenged action," because Barker alleges that she was constructively terminated based solely upon the intolerable work environment created by the Riverside County Office of Education. See id. (quoting Simon v. E. Ky. Welfare Rights Org., 426 U.S. 26, 41, 96 S.Ct. 1917, 48 L.Ed.2d 450 (1976)). Third, Barker's injury "is likely to be redressed" by the compensatory damages requested. See id. (quoting Simon, 426 U.S. at 38, 96 S.Ct. 1917).

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2. See also Weber v. Cranston Sch. Comm., 212 F.3d 41, 48 (1st Cir.2000) (noting that Section 504 integrates the anti-retaliation provision of Title VI of the Civil Rights Act).

3. In Settlegoode v. Portland Public Schools, 371 F.3d 503, 512 n. 6 (9th Cir.2004), we upheld a jury's verdict in favor of a special education teacher who sued her school district for retaliation pursuant to section 504 of the Rehabilitation Act. The teacher sued because the district did not renew her teaching contract after she voiced concerns that the district was discriminating against her disabled students. Id. at 507. In our Settlegoode opinion, however, we did not directly examine whether the teacher had standing pursuant to section 504. As a matter of interest, in an unpublished disposition we also extended protection against retaliation under section 504 of the Rehabilitation Act to a school psychiatrist who advocated on behalf of her disabled students. See Sweet v. Tigard-Tualatin School District, 124 Fed.Appx. 482, 483 (9th Cir.2005); see also Corrales v. Moreno Valley Unified Sch. Dist., No. EDCV-08-00040-SGL, 2008 WL 4382507, at *2-3 (C.D.Cal. Aug.29, 2008) (granting standing under section 504 of the Rehabilitation Act to a special education teacher whose teaching contract was not renewed after she advocated for her students with disabilities).

4. Also persuasive is the Office for Civil Rights' conclusion that "the preponderance of the evidence showed that [the Riverside County Office of Education] retaliated against [Barker] in violation of Section 504[and] Title II."

5. The district court also found that "the Zimmerman case foreclose[d] [Barker]'s claim based on 504 of the Rehabilitation Act," because a "side-by-side comparison of the relevant statutory language" in section 504 and Title II of the ADA shows that the two statutes are "virtually identical." Again, we find that the district court erred in finding that Zimmerman "compell[ed] a conclusion contrary to that reached by the Weber court" under section 504.

PREGERSON, Circuit Judge:

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provide for making medical assistance available to individuals described in subsection (a) of section 1396r–1c of this title during a presumptive eligibility period in accordance with such section"; and

(2) in subparagraph (B), by striking "or 1396r–1b of this title" and inserting "1396r–1b, or 1396r–1c of this title".

AMENDMENT OF SUBSECTION (e)(14)

For repeal of amendment by section 3(e) of Pub. L. 111–255, see Effective and Termination Dates of 2010 Amendment note below.

Pub. L. 111–148, title II, § 2002(a), (c), Mar. 23, 2010, 124 Stat. 279, 282; Pub. L. 111–152, title I, § 1004(b)(1)(A), (e), Mar. 30, 2010, 124 Stat. 1034, 1036, provided that, effective Jan. 1, 2014, subsection (e) of this section is amended by adding at the end the following:

(14) Income determined using modified adjusted gross income.—

(A) In general.—Notwithstanding subsection (r) or any other provision of this subchapter, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on March 23, 2010. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified adjusted gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this subchapter and subchapter XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

(B) No income or expense disregards.—Subject to subparagraph (I), no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

(C) No assets test.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

(D) Exceptions.—

(i) Individuals eligible because of other aid or assistance, elderly individuals, medically needy individuals, and individuals eligible for medicare cost-sharing.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under subchapter XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

(II) Individuals who have attained age 65.

(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under subchapter XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of paragraph (3).

(IV) Individuals described in subsection (a)(10)(C).

(V) Individuals described in any clause of subsection (a)(10)(E).

(ii) Express lane agency findings.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

(iii) Medicare prescription drug subsidies determinations.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1395w–114 of this title made by the State pursuant to section 1396u–5(a)(2) of this title.

(iv) Long-term care.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1396n of this title or a waiver under section 1315 of this title, and services described in section 1396p(c)(1)(C)(ii) of this title.

(v) Grandfather of current enrollees until date of next regular redetermination.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified adjusted gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied

to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

(E) Transition planning and oversight.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified adjusted gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on March 23, 2010. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on March 23, 2010, no longer being eligible for such assistance.

(F) Limitation on secretarial authority.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1396n(h)(2)(B) of this title) under the State plan or under a waiver of the plan and under subchapter XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

(G) Definitions of modified adjusted gross income and household income.—In this paragraph, the terms "modified adjusted gross income" and "household income" have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

(H) Continued application of medicaid rules regarding point-in-time income and sources of income.—The requirement under this paragraph for States to use modified adjusted gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

(i) the requirement under this subchapter and under the State plan or a waiver of the plan to determine an individual's income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

(ii) any rules established under this subchapter or under the State plan or a waiver of the plan regarding sources of countable income.

(I) Treatment of portion of modified adjusted gross income.—For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall—

(i) determine the dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the poverty line) and such upper income limit increased by 5 percentage points; and

(ii) notwithstanding the requirement in subparagraph (A) with respect to use of modified adjusted gross income, utilize as the applicable income of such individual, in determining such income eligibility, an amount equal to the modified adjusted gross income applicable to such individual reduced by such dollar equivalent amount.

REFERENCES IN TEXT

Parts A, D, and E of subchapter IV of this chapter, referred to in subsecs. (a), (c), (e)(1), (10), (13)(F)(ii)(I)(aa), (bb), and (*l*)(3), are classified to sections 601 et seq., 651 et seq., and 670 et seq., respectively, of this title.

The Child Nutrition Act of 1966, referred to in subsecs. (a)(7) and (e)(13)(F)(ii)(I)(hh), is Pub. L. 89-642, Oct. 11, 1966, 80 Stat. 885, which is classified generally to chapter 13A (§1771 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1771 of this title and Tables.

The Richard B. Russell National School Lunch Act, referred to in subsecs. (a)(7) and (e)(13)(F)(ii)(I)(gg), is act June 4, 1946, ch. 281, 60 Stat. 230, which is classified generally to chapter 13 (§1751 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1751 of this title and Tables.

Parts A and B of subchapter XVIII of this chapter, referred to in subsec. (a)(10), (13)(B), (C), are classified to sections 1395c et seq. and 1395j et seq., respectively, of this title.

Section 602 of this title, referred to in subsecs. (a)(10)(A)(i)(I) and (e)(10), was repealed and a new section 602 enacted by Pub. L. 104-193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains subsec. (a)(37) or (a)(43).

Section 606 of this title, referred to in subsec. (a)(10)(A)(i)(I), was repealed and a new section 606 enacted by Pub. L. 104-193, title I, §103(a)(1), Aug. 22, 1996, 110 Stat. 2112, and, as so enacted, no longer contains a subsec. (i).

Section 662 of this title, referred to in subsec. (a)(10)(A)(i)(I), was repealed by Pub. L. 104-193, title I, §108(e), Aug. 22, 1996, 110 Stat. 2167.

The date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, referred to in subsec. (a)(10)(A)(i)(II)(aa), is the date of enactment of Pub. L. 104-193, which was approved Aug. 22, 1996. Section 211(a) of the Act amended section 1382c of this title.

Section 303(a)(4)(A) of this title, referred to in subsec. (a)(20)(C), was amended generally by Pub. L. 97-35, title XXIII, §2353(a)(1)(A), Aug. 13, 1981, 95 Stat. 871, and, as so amended, no longer contained cls. (i) and (ii). Section 303(a)(4) was amended by Pub. L. 103-66, title XIII, §13741(b), Aug. 10, 1993, 107 Stat. 663, and, as so amended, no longer contains subparagraphs.

Section 1383(a)(4)(A)(i) and (ii) of this title, referred to in subsec. (a)(20)(C), is a reference to section 1383(a)(4)(A)(i) and (ii) existing prior to the general revision of subchapter XVI of this chapter by Pub. L. 92-603, title III, §301, Oct. 30, 1972, 86 Stat. 1465, eff. Jan. 1, 1974. The prior section (which is set out as a note under section 1383 of this title) continues in effect for Puerto Rico, Guam, and the Virgin Islands. Subsec. (a)(4) of the prior section was amended generally by Pub. L. 97-35, title XXIII, §2353(m)(2)(B), Aug. 13, 1981, 95 Stat. 973, and, as so amended, no longer contained clauses in subpar. (A). Subsec. (a)(4) of the prior section was also amended by Pub. L. 103-66, title XIII, §13741(b),

Aug. 10, 1993, 107 Stat. 663, and, as so amended, no longer contains subparagraphs.

The Public Health Service Act, referred to in subsecs. (a)(81), (82)(A), (u)(3) and (aa)(3), is act July 1, 1944, ch. 373, 58 Stat. 682. Titles XV, XXII, and XXXII of the Act are classified generally to subchapters XIII (§300k et seq.), XX (§300bb–1 et seq.), and XXX (§300ll et seq.), respectively, of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Public Law 92-336, referred to in provisions following subsec. (a)(68), is Pub. L. 92-336, July 1, 1972, 86 Stat. 406, which amended sections 401, 403, 409, 411, 415, 427, 428, and 430 of this title and sections 165, 1401, 1402, 3101, 3111, 3121, 3122, 3125, 6413, and 6654 of Title 26, Internal Revenue Code, and enacted provisions set out as notes under sections 403, 409, 415, and 428 of this title and sections 165 and 1401 of Title 26.

Part B of subchapter XI of this chapter, referred to in subsec. (d), is classified to section 1320c et seq. of this title.

The Food and Nutrition Act of 2008, referred to in subsec. (e)(13)(F)(ii)(I)(ee), is Pub. L. 88-525, Aug. 31, 1964, 78 Stat. 703, which is classified generally to chapter 51 (§2011 et seq.) of Title 7, Agriculture. For complete classification of this Act to the Code, see Short Title note set out under section 2011 of Title 7 and Tables.

The Head Start Act, referred to in subsec. (e)(13)(F)(ii)(I)(ff), is subchapter B (§635 et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97-35, Aug. 13, 1981, 95 Stat. 499, which is classified generally to subchapter II (§9831 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 9801 of this title and Tables.

The Child Care and Development Block Grant Act of 1990, referred to in subsec. (e)(13)(F)(ii)(I)(ii), is subchapter C (§658A et seq.) of chapter 8 of subtitle A of title VI of Pub. L. 97-35, as added by Pub. L. 101-508, title V, §5082(2), Nov. 5, 1990, 104 Stat. 1388-236, which is classified generally to subchapter II-B (§9858 et seq.) of chapter 105 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 9801 of this title and Tables.

The Stewart B. McKinney Homeless Assistance Act, referred to in subsec. (e)(13)(F)(ii)(I)(jj), was Pub. L. 100-77, July 22, 1987, 101 Stat. 482. Pub. L. 100-77 was renamed the McKinney-Vento Homeless Assistance Act by Pub. L. 106-400, §1, Oct. 30, 2000, 114 Stat. 1675, and is classified principally to chapter 119 (§11301 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 11301 of this title and Tables.

The United States Housing Act of 1937, referred to in subsec. (e)(13)(F)(ii)(I)(kk), is act Sept. 1, 1937, ch. 896, as revised generally by Pub. L. 93-383, title II, §201(a), Aug. 22, 1974, 88 Stat. 653, which is classified generally to chapter 8 (§1437 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 1437 of this title and Tables.

The Native American Housing Assistance and Self-Determination Act of 1996, referred to in subsec. (e)(13)(F)(ii)(I)(ll), is Pub. L. 104-330, Oct. 26, 1996, 110 Stat. 4016, which is classified principally to chapter 43 (§4101 et seq.) of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 4101 of Title 25 and Tables.

The Internal Revenue Code of 1986, referred to in subsec. (u)(3), is classified generally to Title 26.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (u)(3), is Pub. L. 93-406, Sept. 2, 1974, 88 Stat. 829. Title VI of the Act probably means part 6 of subtitle B of title I of the Act which is classified generally to part 6 (§1161 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor, because the Act has no title VI. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

Section 2701 of the Public Health Service Act, referred to in subsec. (aa)(4), is section 2701 of act July 1, 1944, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111-148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg-3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111-148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

Section 1710(1) of the Government Paperwork Elimination Act, referred to in subsec. (dd), is section 1710(1) of Pub. L. 105-277, which is set out in a note under section 3504 of Title 44, Public Printing and Documents.

The Alaska Native Claims Settlement Act, referred to in subsec. (ff)(1), is Pub. L. 92-203, Dec. 18, 1971, 85 Stat. 688, which is classified generally to chapter 33 (§1601 et seq.) of Title 43, Public Lands. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 43 and Tables.

Section 1396cc of this title, referred to in subsec. (kk)(1) to (3), (4)(A)(i), was in the original "section 1686" and was translated as reading "section 1866", meaning section 1866 of act Aug. 14, 1935, to reflect the probable intent of Congress.

Section 1396cc(j)(4), (6), and (7) of this title, referred to in subsec. (kk)(3), (4)(A)(i), (5), were redesignated section 1396cc(j)(5), (7), and (8), respectively, by Pub. L. 111-152, title I, §1004(1), Mar. 30, 2010, 124 Stat. 1056.

CODIFICATION

In subsec. (a)(4)(D), "chapter 21 of title 41" substituted for "section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423)" and "section 2102(a)(3) of title 41" substituted for "subsection (a)(2) of such section of that Act" on authority of Pub. L. 111-350, §6(b), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

AMENDMENTS

2010—Subsec. (a)(7). Pub. L. 111-336, §103(c)(1), amended par. (7) generally. Prior to amendment, par. (7) read as follows: "provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with—

"(A) the administration of the plan; and

"(B) at State option, the exchange of information necessary to verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 and free or reduced price lunches under the Richard B. Russell National School Lunch Act, in accordance with section 9(b) of that Act, using data standards and formats established by the State agency;".

Subsec. (a)(9)(D). Pub. L. 111-148, §6103(d)(2), added subpar. (D).

Subsec. (a)(10). Pub. L. 111-309, §205(f)(1)(A), in concluding provisions, struck out "and" before "(XV) the medical" and substituted "(XVII) if" for "(XV) if".

Pub. L. 111-148, §10201(a)(2), which directed amendment of par. (10) in the matter following subparagraph (G) by substituting "(XV)" for "and (XV)" and inserting "and (XVI) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII)" before the semicolon, was executed by making the insertion only, to reflect the probable intent of Congress. The substitution could not be executed because "and (XV)" did not appear after amendment by Pub. L. 111-148, §2303(a)(3). See below.

Pub. L. 111-148, §2303(a)(3), in concluding provisions, substituted "(XV)" for "and (XV)" and inserted before semicolon at end ", and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and

supplies described in section 1396d(a)(4)(C) of this title including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting".

Pub. L. 111–148, §2001(a)(5)(A), in concluding provisions, substituted "(XIV)" for "and (XIV)" and inserted before semicolon at end "and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)".

Subsec. (a)(10)(A). Pub. L. 111–148, §2301(b), substituted ", (21), and (28)" for "and (21)" in introductory provisions.

Subsec. (a)(10)(A)(i)(VIII). Pub. L. 111–148, §2001(a)(1), added subcl. (VIII).

Subsec. (a)(10)(A)(ii)(XX). Pub. L. 111–148, §2001(a)(1)(A), added subcl. (XX).

Subsec. (a)(10)(A)(ii)(XXI). Pub. L. 111–148, §2303(a)(1), added subcl. (XXI).

Subsec. (a)(10)(A)(ii)(XXII). Pub. L. 111–148, §2402(d)(1), added subcl. (XXII).

Subsec. (a)(10)(E)(iv). Pub. L. 111–309, §110(a), substituted "December 2011" for "December 2010".

Subsec. (a)(13)(C). Pub. L. 111–152, §1202(a)(1)(A), added subpar. (C).

Subsec. (a)(17). Pub. L. 111–255, §3(c)(1), (e), temporarily inserted "(e)(14)," before "(f)(3)", See Effective and Termination Dates of 2010 Amendment note below.

Subsec. (a)(23). Pub. L. 111–309, §205(f)(1)(B), which directed amendment by substituting "(kk)" for "(ii)", was executed by substituting "(kk)(4)" for "(ii)(4)", to reflect the probable intent of Congress.

Pub. L. 111–148, §6401(b)(3), inserted before semicolon at end "or by a provider or supplier to which a moratorium under subsection (ii)(4) is applied during the period of such moratorium".

Subsec. (a)(39). Pub. L. 111–148, §6501, inserted "terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1320a–7(c)(3)(B) and 1320a–7(d)(3)(B) of this title) participation of such individual or entity is terminated under subchapter XVIII or any other State plan under this subchapter," after "1320a–7a of this title,".

Subsec. (a)(42). Pub. L. 111–148, §6411(a)(1), substituted "provide that—" for "provide that", inserted subpar. (A) designation before "the records" and "and" after semicolon at end, and added subpar. (B).

Subsec. (a)(74). Pub. L. 111–148, §4302(b)(1)(A)(i), which directed amendment of "paragraph 4)" by striking "and" at the end, was executed to par. (74) to reflect the probable intent of Congress.

Pub. L. 111–148, §2001(b)(1), added par. (74).

Subsec. (a)(75). Pub. L. 111–148, §4302(b)(1)(A)(ii), substituted "; and" for period at end.

Pub. L. 111–148, §2001(d)(1), added par. (75).

Subsec. (a)(76). Pub. L. 111–148, §4302(b)(1)(A)(iii), added par. (76).

Subsec. (a)(77). Pub. L. 111–309, §205(f)(1)(C), substituted "(kk)" for "(ii)".

Pub. L. 111–148, §6401(b)(1)(A), added par. (77).

Subsec. (a)(78). Pub. L. 111–309, §205(a), struck out par. (78). Text read as follows: "provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

"(A) has unpaid overpayments (as defined by the Secretary) under this subchapter during such period determined by the Secretary or the State agency to be delinquent;

"(B) is suspended or excluded from participation under or whose participation is terminated under this subchapter during such period; or

"(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this subchapter or whose participation is terminated under this subchapter during such period;".

Pub. L. 111–148, §6502, added par. (78).

Subsec. (a)(79). Pub. L. 111–148, §6503, added par. (79).

Subsec. (a)(80). Pub. L. 111–148, §6505, added par. (80).

Subsec. (a)(81). Pub. L. 111–148, §8002(a)(2), added par. (81).

Subsec. (a)(82). Pub. L. 111–148, §8002(b), added par. (82).

Subsec. (a)(83). Pub. L. 111–148, §3021(b), added par. (83).

Subsec. (e)(1)(B). Pub. L. 111–309, §111, substituted "December 31, 2011" for "December 31, 2010".

Subsec. (e)(13)(F)(ii). Pub. L. 111–148, §2901(c), inserted "and indian tribes and tribal organizations" after "agencies" in heading and added subcl. (IV).

Subsec. (e)(14). Pub. L. 111–255, §3(c)(1), (e), temporarily added par. (14). See Effective and Termination Dates of 2010 Amendment note below.

Subsec. (k). Pub. L. 111–148, §2001(a)(2)(A), added pars. (2) and (3).

Pub. L. 111–148, §2001(a)(2)(A), added subsec. (k).

Subsec. (k)(2). Pub. L. 111–148, §10201(b), substituted "April 1, 2010" for "January 1, 2011".

Subsec. (l)(2)(C). Pub. L. 111–309, §205(b), substituted "100 percent (or, beginning January 1, 2014, 133 percent)" for "133 percent".

Pub. L. 111–148, §2001(a)(6)(B), substituted "133" for "100".

Subsec. (gg). Pub. L. 111–148, §2001(b)(2), added subsec. (gg).

Subsec. (gg)(4)(A). Pub. L. 111–152, §1004(b)(1)(B), substituted "modified adjusted gross income" for "modified gross income" in heading.

Subsec. (hh). Pub. L. 111–148, §2001(e)(1)(B), added subsec. (hh).

Subsec. (ii). Pub. L. 111–309, §205(f)(1)(E), redesignated subsec. (ii) relating to provider and supplier screening, oversight, and reporting requirements as (kk).

Pub. L. 111–148, §6401(b)(1)(B), added subsec. (ii) relating to provider and supplier screening, oversight, and reporting requirements.

Pub. L. 111–148, §2303(a)(2), added subsec. (ii) relating to State eligibility option for family planning services.

Subsec. (ii)(2). Pub. L. 111–309, §205(f)(1)(D), substituted "(XVI)" for "(XV)".

Subsec. (jj). Pub. L. 111–152, §1202(a)(1)(B), added subsec. (jj).

Subsec. (kk). Pub. L. 111–309, §205(f)(1)(E), redesignated subsec. (ii) relating to provider and supplier screening, oversight, and reporting requirements as (kk).

2009—Subsec. (a)(10)(E)(iv). Pub. L. 111–5, §5005(a), substituted "December 2010" for "December 2009".

Subsec. (a)(25)(I)(i). Pub. L. 111–3, §203(d)(3), inserted "(and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1396a(e)(13)(D) of this title)" after "with respect to individuals who are eligible" and "under this subchapter (and, at State option, child health assistance under subchapter XXI)" after "the State plan".

Subsec. (a)(43)(D)(iii). Pub. L. 111–3, §501(e)(1), inserted "and other information relating to the provision of dental services to such children described in section 1397hh(c) of this title" after "receiving dental services,".

Subsec. (a)(46). Pub. L. 111–3, §211(a)(1)(A)(i), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(72). Pub. L. 111–3, §501(d)(1), added par. (72).

Subsec. (a)(73). Pub. L. 111–5, §5006(e)(2)(A), added par. (73).

Subsec. (e)(1)(B). Pub. L. 111–5, §5004(a)(1), substituted "December 31, 2010" for "September 30, 2003".

Subsec. (e)(4). Pub. L. 111–3, §211(b)(3)(B), inserted at end "Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1396b(v) of this title, the State immediately shall issue

a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth."

Pub. L. 111–3, §113(b)(1), struck out "so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance" before period at end of first sentence.

Subsec. (e)(13). Pub. L. 111–3, §203(a)(1), added par. (13).

Subsec. (dd). Pub. L. 111–3, §203(c), added subsec. (dd).

Subsec. (ee). Pub. L. 111–3, §211(a)(1)(A)(ii), added subsec. (ee).

Subsec. (ff). Pub. L. 111–5, §5006(b)(1), added subsec. (ff).

2008—Subsec. (a)(10)(E)(iv). Pub. L. 110–275 substituted "December 2009" for "June 2008".

Subsec. (a)(71). Pub. L. 110–252 added par. (71).

2007—Subsec. (a)(10)(E)(iv). Pub. L. 110–173 substituted "June 2008" for "December 2007".

Pub. L. 110–90 substituted "December 2007" for "September 2007".

2006—Subsec. (a)(10)(A)(i)(II). Pub. L. 109–171, §6065(a), inserted "(aa)" after "(II)", substituted "and" for ") and" after "P.L. 104–193)", substituted "section), (bb) who are" for "section or who are", and inserted before comma at end ", or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI if subparagraphs (A) and (B) of section 1382(e)(7) of this title were applied without regard to the phrase 'the first day of the month following' ".

Subsec. (a)(10)(A)(ii)(XIX). Pub. L. 109–171, §6062(a)(1)(A), added subcl. (XIX).

Subsec. (a)(25)(A). Pub. L. 109–171, §6035(a)(1), in introductory provisions, inserted ", self-insured plans" after "health insurers" and substituted "managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service" for "and health maintenance organizations".

Subsec. (a)(25)(G). Pub. L. 109–171, §6035(a)(2), inserted "a self-insured plan," before "a service benefit plan" and substituted "a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service" for "and a health maintenance organization".

Subsec. (a)(25)(I). Pub. L. 109–171, §6035(b), added subpar. (I).

Subsec. (a)(68). Pub. L. 109–171, §6032(a), added par. (68).

Subsec. (a)(69). Pub. L. 109–171, §6034(b), as amended by Pub. L. 109–432, added par. (69).

Subsec. (a)(70). Pub. L. 109–171, §6083(a), added par. (70).

Subsec. (cc). Pub. L. 109–171, §6062(a)(1)(B), added subsec. (cc).

Subsec. (cc)(2). Pub. L. 109–171, §6062(a)(2), added par. (2).

2005—Subsec. (a)(10)(E)(iv). Pub. L. 109–91 substituted "September 2007" for "September 2006".

2004—Subsec. (a)(7). Pub. L. 108–265 designated part of existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(10)(E)(iv). Pub. L. 108–448 substituted "2005" for "2004".

2003—Subsec. (a)(10)(E)(iv). Pub. L. 108–173, §103(f)(1), substituted "ending with September 2004" for "ending with March 2004".

Pub. L. 108–89 substituted "March 2004" for "December 2002", redesignated introductory provisions and subcl. (I) as cl. (iv), substituted semicolon for ", and" after "State plan", and struck out subcl. (II) which read as follows: "for the portion of medicare cost-sharing described in section 1395d(p)(3)(A)(ii) of this title that is attributable to the operation of the amendments made by (and subsection (e)(3) of) section 4611 of the Balanced Budget Act of 1997 for individuals who would be described in subclause (I) if '135 percent' and '175 percent' were substituted for '120 percent' and '135 percent' respectively;".

Subsec. (a)(66). Pub. L. 108–173, §103(a)(1), added par. (66).

Subsec. (a)(67). Pub. L. 108–173, §236(b)(1), added par. (67).

Subsec. (e)(1)(B). Pub. L. 108–40 substituted "2003" for "2002".

2002—Subsec. (a)(15). Pub. L. 107–121, §2(b)(2), substituted "subsection (bb)" for "subsection (aa)".

Subsec. (aa). Pub. L. 107–121, §2(b)(1), redesignated subsec. (aa) relating to payment for services provided by federally-qualified health centers and rural health clinics as subsec. (bb).

Subsec. (aa)(4). Pub. L. 107–121, §2(a), inserted ", but applied without regard to paragraph (1)(F) of such section" before period at end.

Subsec. (bb). Pub. L. 107–121, §2(b)(1), redesignated subsec. (aa) relating to payment for services provided by federally-qualified health centers and rural health clinics as subsec. (bb).

2000—Subsec. (a)(10). Pub. L. 106–354, §2(a)(3), in concluding provisions, substituted "(XIII)" for "and (XIII)" and inserted before semicolon at end ", and (XIV) the medical assistance made available to an individual described in subsection (aa) of this section who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer".

Subsec. (a)(10)(A)(ii)(XVIII). Pub. L. 106–354, §2(a)(1), added subcl. (XVIII).

Subsec. (a)(13)(A)(iv). Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(1)(A)], inserted "and" at end.

Subsec. (a)(13)(B). Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(1)(B)], struck out "and" at end.

Subsec. (a)(13)(C). Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1)], repealed Pub. L. 105–33, §4712(c)(1). See 1997 Amendment note below.

Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(1)(C)], struck out subpar. (C) which read as follows: "(C)(i) for payment for services described in clause (B) or (C) of section 1396d(a)(2) of this title under the plan of 100 percent (or 95 percent for services furnished during fiscal year 2000, fiscal year 2001, or fiscal year 2002, 90 percent for services furnished during fiscal year 2003, or 85 percent for services furnished during fiscal year 2004) of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes in regulations under section 1395l(a)(3) of this title, or, in the case of services to which those regulations do not apply, on the same methodology used under section 1395l(a)(3) of this title and (ii) in carrying out clause (i) in the case of services furnished by a Federally-qualified health center or a rural health clinic pursuant to a contract between the center and an organization under section 1396b(m) of this title, for payment to the center or clinic at least quarterly by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract;".

Subsec. (a)(15). Pub. L. 106–554, §1(a)(6) [title VII, §702(a)(2)], added par. (15).

Subsec. (a)(47). Pub. L. 106–354, §2(b)(2)(A), inserted before semicolon at end "and provide for making medical assistance available to individuals described in subsection (a) of section 1396r-1b of this title during a presumptive eligibility period in accordance with such section".

Subsec. (e)(1)(B). Pub. L. 106–554, §1(a)(6) [title VII, §707(b)], substituted "2002" for "2001".

Subsec. (aa). Pub. L. 106–554, §1(a)(6) [title VII, §702(b)], added subsec. (aa) relating to payment for services provided by Federally-qualified health centers and rural health clinics.

Pub. L. 106–354, §2(a)(2), added subsec. (aa) relating to certain breast or cervical cancer patients.

1999—Subsec. (a)(10)(A)(ii)(XIV). Pub. L. 106–113, §1000(a)(6) [title VI, §608(aa)(1)], substituted "1396d(u)(2)(B) of this title" for "1396d(u)(2)(C) of this title".

Subsec. (a)(10)(A)(ii)(XV). Pub. L. 106–169, §121(c)(4)(A), redesignated subcl. (XV), related to individuals who are independent foster care adolescents, as (XVII).

Pub. L. 106–169, §121(a)(1)(C), added subcl. (XV), related to individuals who are independent foster care adolescents.

Pub. L. 106–169, §121(a)(1)(A), which directed striking out "or" at end of subcl. (XIII), was executed by amending subcl. (XV), related to individuals who would be considered to be receiving supplemental security income, etc. See Construction of 1999 Amendment note below.

Pub. L. 106–170, §201(a)(1), added subcl. (XV), related to individuals who would be considered to be receiving supplemental security income, etc.

Subsec. (a)(10)(A)(ii)(XVI). Pub. L. 106–169, §121(a)(1)(B), which directed insertion of "or" at end of subcl. (XIV), was executed to subcl. (XVI). See Construction of 1999 Amendment note below.

Pub. L. 106–170, §201(a)(2)(A), added subcl. (XVI).

Subsec. (a)(10)(A)(ii)(XVII). Pub. L. 106–169, §121(c)(4), redesignated subcl. (XV), related to individuals who are independent foster care adolescents, as (XVII) and substituted "section 1396d(w)(1)" for "section 1396d(v)(1)".

Subsec. (a)(10)(G). Pub. L. 106–169, §206(b), substituted "subsections (c) and (e) of section 1382b" for "section 1382b(e)".

Pub. L. 106–169, §205(c), added subpar. (G).

Subsec. (a)(13)(C)(i). Pub. L. 106–113, §1000(a)(6) [title VI, §603(a)(1)], substituted "fiscal year 2001, or fiscal year 2002, 90 percent for services furnished during fiscal year 2003, or 85 percent for services furnished during fiscal year 2004" for "90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003".

Subsec. (a)(30)(A). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(1)(A)], inserted "and" at end.

Subsec. (a)(30)(B)(ii). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(1)(B)], struck out "and" at end.

Subsec. (a)(30)(C). Pub. L. 106–113, §1000(a)(6) [title VI, §604(b)(1)(C)], struck out subpar. (C) which read as follows: "use a utilization and quality control peer review organization (under part B of subchapter XI of this chapter), an entity which meets the requirements of section 1320c–1 of this title, as determined by the Secretary, or a private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1396b(m) of this title, with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;".

Subsec. (a)(60). Pub. L. 106–113, §1000(a)(6) [title VI, §608(y)(2)], made technical amendment to reference in original act which appears in text as reference to section 1396g–1 of this title.

Subsec. (a)(64). Pub. L. 106–113, §1000(a)(6) [title VI, §608(a)], inserted "and" at end.

Subsec. (d). Pub. L. 106–113, §1000(a)(6) [title VI, §604(a)(2)(A)], struck out "(including quality review functions described in subsection (a)(30)(C) of this section)" after "medical or utilization review functions".

Pub. L. 106–113, §1000(a)(6) [title VI, §604(a)(1)], struck out "for the performance of the quality review functions described in subsection (a)(30)(C) of this section," before "or a utilization and quality control peer review organization".

Subsec. (j). Pub. L. 106–113, §1000(a)(6) [title VI, §608(b)], substituted "of" for "of of" after "numbered paragraph".

Subsec. (l)(1)(C). Pub. L. 106–113, §1000(a)(6) [title VI, §608(c)(1)], substituted "children" for "children children".

Subsec. (l)(3). Pub. L. 106–113, §1000(a)(6) [title VI, §608(c)(2)], struck out first comma after "(a)(10)(A)(i)(VII)" in introductory provisions.

Subsec. (l)(4)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(c)(3)], inserted comma after "(a)(10)(A)(i)(IV)".

Subsec. (v). Pub. L. 106–113, §1000(a)(6) [title VI, §608(d)], struck out par. (1) designation before "A State plan may provide".

1997—Subsec. (a). Pub. L. 105–33, §4454(b)(1), in second sentence of flush concluding provisions, substituted "to a religious nonmedical health care institution (as defined in section 1395x(ss)(1) of this title)." for "to a Christian Science sanatorium operated, or listed and certified, by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.."

Subsec. (a)(4)(C), (D). Pub. L. 105–33, §4724(c)(1), substituted "(C)" for "and (C)", "local officer, employee, or independent contractor" for "local officer or employee", and "such an officer, employee, or contractor" for "such an officer or employee" in two places and added subpar. (D).

Subsec. (a)(9)(C). Pub. L. 105–33, §4106(c), substituted "paragraphs (16) and (17)" for "paragraphs (15) and (16)".

Subsec. (a)(10)(A)(i)(II). Pub. L. 105–33, §4913(a), inserted "(or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193)) and would continue to be paid but for the enactment of that section" after "subchapter XVI of this chapter".

Subsec. (a)(10)(A)(ii)(XIII). Pub. L. 105–33, §4733, added subcl. (XIII).

Subsec. (a)(10)(A)(ii)(XIV). Pub. L. 105–33, §4911(b), added subcl. (XIV).

Subsec. (a)(10)(E)(iv). Pub. L. 105–33, §4732(a), added cl. (iv).

Subsec. (a)(13)(A). Pub. L. 105–33, §4711(a)(1), added subpar. (A) and struck out former subpar. (A) which related to payment of hospital services, nursing facility services, and services in intermediate care facilities for mentally retarded by use of rates which account for various specified costs.

Subsec. (a)(13)(B). Pub. L. 105–33, §4711(a)(1)–(3), redesignated subpar. (D) as (B), inserted "and" at end, and struck out former subpar. (B) which read as follows: "that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1395x(v)(1)(O) of this title;".

Subsec. (a)(13)(C). Pub. L. 105–33, §4712(c)(1), which directed the repeal of subsec. (a)(13)(C), was repealed by Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(1)]. See 2000 Amendment note above and Effective Date of 1997 Amendment note below.

Pub. L. 105–33, §4712(b)(1), designated existing provisions as cl. (i) and added cl. (ii).

Pub. L. 105–33, §4712(a), inserted "(or 25 percent for services furnished during fiscal year 2000, 90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003)" after "100 percent".

Pub. L. 105–33, §4711(a)(1), (2), (4), redesignated subpar. (D) as (C), struck out "and" at end, and struck out former subpar. (C) which read as follows: "that the State shall provide assurances satisfactory to the Secretary that the valuation of capital assets, for purposes of determining payment rates for nursing facilities and for intermediate care facilities for the mentally retarded, will not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of—

"(i) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as

extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

"(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average);".

Subsec. (a)(13)(D), (E). Pub. L. 105–33, §4711(a)(2), redesignated subpars. (D) and (E) as (B) and (C), respectively.

Subsec. (a)(13)(F). Pub. L. 105–33, §4711(a)(5), struck out subpar. (F) which read as follows: "for payment for home and community care (as defined in section 1396t(a) of this title and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards;".

Subsec. (a)(23). Pub. L. 105–33, §4724(d), struck out "except as provided in subsection (g) of this section and in section 1396n and except in the case of Puerto Rico, the Virgin Islands, and Guam," after "(23)" and inserted before semicolon at end ", except as provided in subsection (g) of this section and in section 1396n of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan".

Subsec. (a)(23)(B). Pub. L. 105–33, §4701(d)(1), substituted ", in section 1396n of this title, and in section 1396u–2(a) of this title" for "and in section 1396n of this title".

Pub. L. 105–33, §4701(b)(2)(A)(i), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (a)(25)(A)(ii). Pub. L. 105–33, §4753(b), substituted "be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;" for the dash that followed "which plan shall" and struck out subcls. (I) and (II) which read as follows:

"(I) be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval system under section 1396b(r) of this title, and

"(II) be subject to the provisions of section 1396b(r)(4) of this title relating to reductions in Federal payments for failure to meet conditions of approval, but shall not be subject to any other financial penalty as a result of any other monitoring, quality control, or auditing requirements;".

Subsec. (a)(25)(G) to (I). Pub. L. 105–33, §4741(a), redesignated subpars. (H) and (I) as (G) and (H), respectively, and struck out former subpar. (G) which read as follows: "that the State plan shall meet the requirements of section 1396e of this title (relating to enrollment of individuals under group health plans in certain cases);".

Subsec. (a)(26). Pub. L. 105–33, §4751(a), substituted "provide, with respect to each patient" for "provide—

"(A) with respect to each patient"

and struck out subpars. (B) and (C) which read as follows:

"(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving medical assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

"(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;".

Subsec. (a)(31). Pub. L. 105–33, §4751(b), substituted "provide, with respect to each patient" for "provide—

"(A) with respect to each patient"

and struck out subpars. (B) and (C) which read as follows:

"(B) with respect to each intermediate care facility for the mentally retarded within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

"(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;".

Subsec. (a)(47). Pub. L. 105–33, §4912(b)(1), inserted before semicolon at end "and provide for making medical assistance for items and services described in subsection (a) of section 1396r–1a of this title available to children during a presumptive eligibility period in accordance with such section".

Subsec. (a)(57). Pub. L. 105–33, §4701(b)(2)(A)(ii), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (a)(63). Pub. L. 105–33, §4724(g)(1)(A), struck out "and" at end.

Subsec. (a)(64). Pub. L. 105–38, §4724(g)(1)(B), which directed the amendment of par. (64) by substituting "; and" for the period at end, could not be executed because there was no period at end.

Pub. L. 105–33, §4724(f), added par. (64).

Subsec. (a)(65). Pub. L. 105–33, §4724(g)(1)(C), added par. (65).

Subsec. (e)(2)(A). Pub. L. 105–33, §4709(2), which directed the amendment of subsec. (e)(2) by inserting "or by or through the case manager" before period at end, was executed by making insertion before period at end of subpar. (A) to reflect the probable intent of Congress.

Pub. L. 105–33, §4709(1), substituted "who is enrolled with a medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title), with a primary care case manager (as defined in section 1396d(t) of this title)," for "who is enrolled with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1396b(m) of this title under a contract described in section 1396b(m)(2)(A) of this title".

Subsec. (e)(12). Pub. L. 105–33, §4731(a), added par. (12).

Subsec. (i)(1)(B). Pub. L. 105–33, §4752(a), substituted "establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide" for "provide".

Subsec. (j). Pub. L. 105–33, §4702(b)(2), substituted "a numbered paragraph of" for "paragraphs (1) through (25)".

Subsec. (l)(1)(D). Pub. L. 105–33, §4731(b), inserted "(or, at the option of a State, after any earlier date)" after "children born after September 30, 1983".

Subsec. (n). Pub. L. 105–33, §4714(a)(1), designated existing provisions as par. (1) and added pars. (2) and (3).

Subsec. (p)(2). Pub. L. 105-33, §4701(b)(2)(A)(iii), substituted "medicaid managed care organization" for "health maintenance organization" in introductory provisions.

Subsec. (r)(1). Pub. L. 105-33, §4715(a), designated existing provisions as subpar. (A), inserted ", the treatment described in subparagraph (B) shall apply," after "under such a waiver", substituted ", and" for "and," after "Federal Republic of Germany", and added subpar. (B).

Subsec. (w)(2)(E). Pub. L. 105-33, §4701(b)(2)(A)(iv), substituted "medicaid managed care organization" for "health maintenance organization".

Subsec. (w)(5). Pub. L. 105-12 added par. (5).

1996—Subsec. (a). Pub. L. 104-193, §913, which directed substitution of "The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc." for "The First Church of Christ, Scientist, Boston, Massachusetts" in third sentence, was executed by making the substitution for "the First Church of Christ, Scientist, Boston, Massachusetts" in first undesignated closing par. to reflect the probable intent of Congress.

Subsec. (a)(25)(A)(i). Pub. L. 104-226 struck out "including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1320b-14 of this title and any additional measures" before "as specified by the Secretary in regulations)".

Subsec. (a)(59). Pub. L. 104-248 substituted "subsection (x)" for "subsection (v)".

Subsec. (a)(63). Pub. L. 104-193, §114(b), added par. (63).

Subsec. (c). Pub. L. 104-193, §114(d)(1), substituted "If the State requires individuals described in subsection (l)(1) of this section to apply for assistance under the State program funded under part A of subchapter IV of this chapter as a condition of applying for or receiving medical assistance under this subchapter," for "If—

"(1) the State has in effect, under its plan established under part A of subchapter IV of this chapter, payment levels that are less than the payment levels in effect under such plan on May 1, 1988; or

"(2) the State requires individuals described in subsection (l)(1) of this section to apply for benefits under such part as a condition of applying for, or receiving, medical assistance under this subchapter,".

Subsec. (e)(1)(B). Pub. L. 104-193, §114(c), substituted "2001" for "1998".

Subsec. (j). Pub. L. 104-193, §108(k), substituted "1308(f)" for "1308(e)".

1994—Subsec. (a)(10)(A)(ii)(XI). Pub. L. 103-296 substituted "Commissioner of Social Security" for "Secretary".

Subsec. (a)(11)(C), (53)(A). Pub. L. 103-448 substituted "special supplemental nutrition program" for "special supplemental food program".

1993—Subsec. (a)(10). Pub. L. 103-66, §13603(c), in concluding provisions, substituted "services, or hospitals, (XI)" for "services, or hospitals; and (XI)" and "other individuals, (XII)" for "other individuals, and (XI)", and inserted ", and" and subdiv. (XIII) before semicolon at end.

Subsec. (a)(10)(A)(ii)(XII). Pub. L. 103-66, §13603(a), added subcl. (XII).

Subsec. (a)(1)(C)(iv). Pub. L. 103-66, §13601(b)(1), substituted "paragraphs numbered (1) through (24)" for "paragraphs numbered (1) through (21)".

Subsec. (a)(11). Pub. L. 103-66, §13631(f)(1)(A), (B), in subpar. (B), struck out "effective July 1, 1969," after "(B)" and "and" before "(ii)" and substituted "to the individual under section 1396b of this title, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services" for "to him under section 1396b of this title", and in subpar. (C), inserted ", including the provision of information and education on pediatric vaccinations and the delivery of immunization services," after "operations under this subchapter".

Subsec. (a)(18). Pub. L. 103-66, §13611(d)(1)(A), substituted ", transfers of assets, and treatment of certain trusts" for "and transfers of assets".

Subsec. (a)(25)(A). Pub. L. 103-66, §13622(a), substituted "insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, and health maintenance organizations)" for "insurers)" in introductory provisions.

Subsec. (a)(25)(A)(i). Pub. L. 103-66, §13581(b)(2), substituted "(including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1320b-14 of this title and any additional measures as specified" for "(as specified".

Subsec. (a)(25)(H). Pub. L. 103-66, §13622(b), added subpar. (H).

Subsec. (a)(25)(I). Pub. L. 103-66, §13622(c), added subpar. (I).

Subsec. (a)(32)(D). Pub. L. 103-66, §13631(e)(1), added subpar. (D).

Subsec. (a)(43)(A). Pub. L. 103-66, §13631(f)(1)(C), inserted before comma at end "and the need for age-appropriate immunizations against vaccine-preventable diseases".

Subsec. (a)(51). Pub. L. 103-66, §13611(d)(1)(B), struck out "(A)" before "meet the requirements" and ", and (B) meet the requirement of section 1396p(c) of this title (relating to transfer of assets)" after "community spouses)".

Subsec. (a)(54). Pub. L. 103-66, §13623(a)(1), which directed amendment of par. (54) by striking "and" at end, could not be executed because "and" did not appear at end subsequent to amendment by Pub. L. 103-66, §13602(c). See below.

Pub. L. 103-66, §13602(c), amended par. (54) generally. Prior to amendment, par. (54) read as follows:

"(A) provide that, any formulary or similar restriction (except as provided in section 1396r-8(d) of this title) on the coverage of covered outpatient drugs under the plan shall permit the coverage of covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under section 1396r-8(a) of this title, which are prescribed for a medically accepted indication (as defined in subsection 1396r-8(k)(6) of this title), and

"(B) comply with the reporting requirements of section 1396r-8(b)(2)(A) of this title and the requirements of subsections (i) and (g) of section 1396r-8 of this title; and".

Subsec. (a)(55). Pub. L. 103-66, §13623(a)(3), redesignated par. (55) relating to providing for adjusted payments as (56).

Pub. L. 103-66, §13623(a)(2), amended par. (55) relating to providing for receipt and initial processing of applications by substituting semicolon for period at end of subpar. (B).

Subsec. (a)(56). Pub. L. 103-66, §13623(a)(3), redesignated par. (55) relating to providing for adjusted payments as (56), transferred such par. to appear after par. (55) relating to providing for receipt and initial processing of applications, and substituted semicolon for period at end.

Subsec. (a)(57). Pub. L. 103-66, §13623(a)(4), transferred par. (57) to appear after par. (56) as redesignated by Pub. L. 103-66, §13623(a)(3). See above.

Subsec. (a)(58). Pub. L. 103-66, §13623(a)(6), redesignated par. (58) relating to maintaining a list as (59).

Pub. L. 103-66, §13623(a)(5), amended par. (58) relating to providing that a State develop a written description of advance directive laws by substituting a semicolon for period at end.

Pub. L. 103-66, §13623(a)(4), transferred par. (58) relating to providing that a State develop a written description of advance directive laws to follow par. (57) which was transferred by Pub. L. 103-66, §13623(a)(4), to appear after par. (56), as redesignated by Pub. L. 103-66, §13623(a)(3). See above.

Subsec. (a)(59). Pub. L. 103-66, §13625(a)(1), struck out "and" at end.

Pub. L. 103-66, §13623(a)(6), redesignated par. (58), relating to maintaining a list, as (59), transferred such par. to appear after par. (58) relating to providing that a State develop a written description of advance directive laws, and substituted "; and" for period at end.

Subsec. (e)(50). Pub. L. 103-66, §13623(a)(7), added par. (60).

Subsec. (a)(61). Pub. L. 103-66, §13625(a), added par. (61).

Subsec. (a)(62). Pub. L. 103-66, §13631(a), added par. (62).

Subsec. (j). Pub. L. 103-66, §13601(b)(2), substituted "paragraphs (1) through (25)" for "paragraphs (1) through (22)".

Subsec. (k). Pub. L. 103-66, §13611(d)(1)(C), struck out subsec. (k) which read as follows:

"(k)(1) In the case of a medicaid qualifying trust (described in paragraph (2)), the amounts from the trust deemed available to a grantor, for purposes of subsection (a)(17) of this section, is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of the previous sentence, the term 'grantor' means the individual referred to in paragraph (2).

"(2) For purposes of this subsection, a 'medicaid qualifying trust' is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

"(3) This subsection shall apply without regard to—

"(A) whether or not the medicaid qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medical assistance under this subchapter; or

"(B) whether or not the discretion described in paragraph (2) is actually exercised.

"(4) The State may waive the application of this subsection with respect to an individual where the State determines that such application would work an undue hardship."

Subsec. (z). Pub. L. 103-66, §13603(b), added subsec. (z).

1991—Subsec. (h). Pub. L. 102-234, §3(a), struck out "to limit the amount of payment adjustments that may be made under a plan under this subchapter with respect to hospitals that serve a disproportionate number of low-income patients with special needs or" after "Secretary".

Subsec. (t). Pub. L. 102-234, §2(b)(1), substituted "Nothing" for "Except as provided in section 1396b(l) of this title, nothing" and "taxes of general applicability" for "taxes (whether or not of general applicability)".

1990—Subsec. (a)(10). Pub. L. 101-508, §4713(a)(1)(D), which directed amendment of par. (10) by adding subdiv. (XI), relating to medical assistance available to an individual described in subsection (u)(1), in the matter following subparagraph (E), was executed in the matter following subpar. (F) to reflect the probable intent of Congress and the intervening amendment by Pub. L. 101-508, §4713(a)(1)(A)-(C), which added subpar. (F). See below. Direction by section 4713(a)(1)(D) to strike "and" before "(X)" could not be executed because "and" did not appear after amendment by Pub. L. 101-508, §4402(d)(1). See below.

Pub. L. 101-508, §4402(d)(1), in closing provisions, struck out "and" at end of subdiv. (IX), inserted "and" at end of subdiv. (X), and added subdiv. (XI) relating to medical assistance to cover costs of premiums, etc.

Subsec. (a)(10)(A)(i)(VII). Pub. L. 101-508, §4601(a)(1)(A), added subcl. (VII).

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 101-508, §4601(a)(1)(B), substituted ", clause (i)(VI), or clause (i)(VII)" for "or clause (i)(VI)".

Subsec. (a)(10)(G)(iv). Pub. L. 101-508, §§4711(d)(2), 4755(c)(1)(A), amended cl. (iv) identically, substituting "through (21)" for "through (20)".

Subsec. (a)(10)(E)(iii). Pub. L. 101-508, §4591(b), added cl. (iii).

Subsec. (a)(10)(F). Pub. L. 101-508, §4713(a)(1)(A)-(C), added subpar. (F).

Subsec. (a)(13)(A). Pub. L. 101-508, §4601(c)(1)(A), inserted "(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter)" after "take into account the costs".

Subsec. (a)(13)(E). Pub. L. 101-508, §4704(a)(1), repealed Pub. L. 101-239, §6402(c)(2). See 1989 Amendment note below.

Pub. L. 101-508, §4704(a), substituted "prescribes" for "may prescribe" and "on the same methodology used under section 1395l(a)(3) of this title" for "on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph".

Subsec. (a)(13)(F). Pub. L. 101-508, §4711(c)(1)(A), added subpar. (F).

Subsec. (a)(17). Pub. L. 101-508, §4723(b), inserted ", payments made to the State under section 1396b(f)(2)(B) of this title," after "insurance premiums".

Subsec. (a)(25)(G). Pub. L. 101-508, §4402(a)(1), added subpar. (G).

Subsec. (a)(32)(C). Pub. L. 101-508, §4708(a), added subpar. (C).

Subsec. (a)(41). Pub. L. 101-508, §4754(a), substituted "shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board" for "shall promptly notify the Secretary".

Subsec. (a)(54). Pub. L. 101-508, §4401(a)(2), added par. (54).

Subsec. (a)(55). Pub. L. 101-508, §4604(b), added par. (55) relating to providing for adjusted payments.

Pub. L. 101-508, §4602(a), added par. (55) relating to providing for receipt and initial processing of applications.

Subsec. (a)(57). Pub. L. 101-508, §4751(a)(1), added par. (57).

Subsec. (a)(58). Pub. L. 101-508, §4752(c), added par. (58) relating to maintaining a list.

Pub. L. 101-508, §4751(a)(1), added par. (58) relating to providing that a State develop a written description of advance directive laws.

Subsec. (e)(2)(A). Pub. L. 101-508, §4732(b)(1), inserted "or with an eligible organization with a contract under section 1395mm of this title" after "section 1396b(m)(2)(A) of this title".

Subsec. (e)(4). Pub. L. 101-508, §4603(a)(1), inserted "(or would remain if pregnant)" after "remains".

Subsec. (e)(6). Pub. L. 101-508, §4603(a)(2), substituted "In" for "At the option of a State, in", substituted "the woman shall be deemed to continue to be" for "the State plan may nonetheless treat the woman as being", and inserted at end "The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1396r-1 of this title during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan."

Subsec. (e)(11). Pub. L. 101-508, §4402(c), added par. (11).

Subsec. (b). Pub. L. 101-508, §4711(c)(1)(B), inserted before period at end "or to limit the amount of payment that may be made under a plan under this subchapter for home and community care".

Subsec. (j). Pub. L. 101-508, §§4711(d)(1), 4755(c)(1)(B), amended subsec. (j) identically substituting "through (22)" for "through (21)".

Subsec. (l)(1)(C). Pub. L. 101-508, §4601(a)(1)(C)(i), inserted "children" after "(C)".

Subsec. (l)(1)(D). Pub. L. 101-508, §4601(a)(1)(C)(ii), added subpar. (D) and struck out former subpar. (D) which read as follows: "at the option of the State, children born after September 30, 1983, who have attained 6 years of age but have not attained 7 or 8 years of age (as selected by the State),".

Subsec. (l)(2)(C). Pub. L. 101-508, §4601(a)(1)(C)(iii), added subpar. (C) and struck out former subpar. (C) which read as follows: "If a State elects, under sub-

section (a)(10)(A)(ii)(IX) of this section, to cover individuals not described in subparagraph (A) or (B) of paragraph (1), for purposes of that paragraph and with respect to individuals not described in such subparagraphs the State shall establish an income level which is a percentage (not more than 100 percent) of the income official poverty line described in subparagraph (A)."

Subsec. (*l*)(3). Pub. L. 101–508, §4601(a)(1)(C)(iv), inserted "; (a)(10)(A)(i)(VII)," after "(a)(10)(A)(i)(VI)".

Subsec. (*l*)(4)(A). Pub. L. 101–508, §4601(a)(1)(C)(v), inserted "or subsection (a)(10)(A)(i)(VII) of this section" after "(a)(10)(A)(i)(VI) of this section".

Subsec. (*l*)(4)(B). Pub. L. 101–508, §4601(a)(1)(C)(vi), substituted "(a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII)" for "or (a)(10)(A)(i)(VI)".

Subsec. (m)(1)(B). Pub. L. 101–508, §4601(c)(2)(A), inserted ", except as provided in paragraph (2)(C)" after "program".

Subsec. (m)(2)(C). Pub. L. 101–508, §4601(c)(2)(B), added subpar. (C).

Subsec. (r)(1). Pub. L. 101–508, §4715(a), inserted "there shall be disregarded reparation payments made by the Federal Republic of Germany and" after "under such a waiver".

Subsec. (r)(2)(A). Pub. L. 101–508, §4601(a)(1)(D), inserted "(a)(10)(A)(i)(VII)," after "(a)(10)(A)(i)(VI),".

Subsec. (s). Pub. L. 101–508, §4604(a), added subsec. (s).

Subsec. (t). Pub. L. 101–508, §4701(b)(1), added subsec. (t).

Subsec. (u). Pub. L. 101–508, §4713(a)(2), added subsec. (u).

Subsec. (v). Pub. L. 101–508, §4724(a), added subsec. (v).

Subsec. (w). Pub. L. 101–508, §4751(a)(2), added subsec. (w).

Subsec. (x). Pub. L. 101–508, §4752(a)(1)(A), added subsec. (x).

Subsec. (y). Pub. L. 101–508, §4755(a)(2), added subsec. (y).

1989—Subsec. (a)(9)(C). Pub. L. 101–239, §6115(c), substituted "paragraphs (15) and (16)" for "paragraphs (14) and (15)".

Pub. L. 101–234 repealed Pub. L. 100–360, §204(d)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (a)(10)(A). Pub. L. 101–239, §6405(b), substituted "(1) through (5), (17) and (21)" for "(1) through (5) and (17)" in introductory provisions.

Subsec. (a)(10)(A)(i)(VI). Pub. L. 101–239, §6401(a)(1), added subcl. (VI).

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 101–239, §6401(a)(2), inserted "or clause (i)(VI)" after "clause (i)(IV)".

Subsec. (a)(10)(B). Pub. L. 101–239, §6408(d)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(11)(C). Pub. L. 101–239, §6408(a)(1), added subpar. (C).

Subsec. (a)(13)(D). Pub. L. 101–239, §6409(c)(1), substituted "in amounts no lower than the amounts, using the same methodology, used" for "in the same amounts, and using the same methodology, as used", "in the case of" for "a separate rate may be paid for", and "there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual" for "to take into account the room and board furnished by such facility".

Subsec. (a)(13)(E). Pub. L. 101–239, §6404(c), substituted "clause (B) or (C) of section 1396d(a)(2) of this title" for "section 1396d(a)(2)(B) of this title provided by a rural health clinic".

Pub. L. 101–239, §6402(c)(2), which directed insertion of ", and for payment for services described in section 1396d(a)(2)(C) of this title under the plan," after "provided by a rural health clinic under the plan", was repealed by Pub. L. 101–508, §4704(e)(1).

Subsec. (a)(30)(A). Pub. L. 101–239, §6402(a), inserted before semicolon at end "and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area".

Subsec. (a)(43)(A). Pub. L. 101–239, §6403(d)(1), substituted "section 1396d(r)" for "section 1396d(a)(4)(B)".

Subsec. (a)(43)(D). Pub. L. 101–239, §6403(b), added subpar. (D).

Subsec. (a)(53). Pub. L. 101–239, §6406(a)(2)–(4), added par. (53).

Subsec. (e)(7). Pub. L. 101–239, §6401(a)(3), substituted ", (C), or (D)" for "or (C)" in introductory provisions.

Subsec. (*l*). Pub. L. 101–239, §6411(c)(2), inserted "and section 1396r–5 of this title" after "section 1382h(b)(3) of this title".

Pub. L. 101–239, §6411(a)(1), inserted "and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1) of this subsection" before ", no State".

Pub. L. 101–239, §6408(d)(4)(C), inserted ", except with respect to qualified disabled and working individuals (described in section 1396d(s) of this title)," after "section 1382h(b)(3) of this title".

Subsec. (*l*)(1)(C), (D). Pub. L. 101–239, §6401(a)(3), added subpars. (C) and (D) and struck out former subpar. (C) which read as follows: "at the option of the State, children born after September 30, 1983, who have attained one year of age but have not attained 2, 3, 4, 5, 6, 7, or 8 years of age (as selected by the State);".

Subsec. (*l*)(2)(A)(i)(II). Pub. L. 101–239, §6401(a)(4)(A), amended subcl. (II) generally. Prior to amendment, subcl. (II) read as follows: "July 1, 1990, is 100 percent."

Subsec. (*l*)(2)(A)(iv). Pub. L. 101–239, §6401(a)(4)(B), added cl. (iv).

Subsec. (*l*)(2)(B), (C). Pub. L. 101–239, §6401(a)(5), (6), added subpar. (B), struck out ", or, if less, the percentage established under subparagraph (A)" after "not more than 100 percent" in former subpar. (B), and redesignated former subpar. (B) as (C).

Subsec. (*l*)(3). Pub. L. 101–239, §6401(a)(6)(A), inserted ", (a)(10)(A)(i)(VI)," after "(a)(10)(A)(i)(IV)" in introductory provisions.

Subsec. (*l*)(3)(C). Pub. L. 101–239, §6401(a)(6)(B), substituted "(C), or (D)" for "or (C)".

Subsec. (*l*)(4)(A). Pub. L. 101–239, §6401(a)(7)(A), inserted "and for children described in subsection (a)(10)(A)(i)(VI) of this section" after "(a)(10)(A)(i)(IV) of this section".

Subsec. (*l*)(4)(B). Pub. L. 101–239, §6401(a)(7)(B), inserted "or (a)(10)(A)(i)(VI)" after "(a)(10)(A)(i)(IV)".

Subsec. (p)(2)(C). Pub. L. 101–239, §6411(d)(3)(B), added subpar. (C).

Subsec. (r)(2)(A). Pub. L. 101–239, §6401(a)(9), inserted "(a)(10)(A)(i)(VI)," after "(a)(10)(A)(i)(IV)," in introductory provisions.

1988—Subsec. (a)(9)(C). Pub. L. 100–360, §204(d)(3), substituted "paragraphs (14) and (15)" for "paragraphs (13) and (14)".

Subsec. (a)(10). Pub. L. 100–647, §6434(b)(1), inserted "who is only entitled to medical assistance because the individual is such a beneficiary" after "section 1396d(p)(1) of this title" in subdiv. (VIII) of closing provisions.

Pub. L. 100–360, §302(a)(1)(C), inserted "(A)(i)(IV) or" before "(A)(ii)(X)" in subdiv. (VII) of closing provisions.

Pub. L. 100–360, §302(b)(1), added subdiv. (X) in closing provisions.

Subsec. (a)(10)(A)(i)(I). Pub. L. 100–485, §202(c)(4), substituted "section 562(e)(5) of this title" for "section 614(g) of this title".

Subsec. (a)(10)(A)(i)(IV). Pub. L. 100–360, §302(a)(1)(A), added subcl. (IV).

Subsec. (a)(10)(A)(i)(V). Pub. L. 100–485, §401(d)(1), added subcl. (V).

Subsec. (a)(10)(A)(ii)(VI). Pub. L. 100–360, §411(k)(17)(B), substituted "(c), (d), or (e)" for "(c) or (d)" in two places.

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 100–360, §302(a)(1)(B), amended subcl. (IX) generally. Prior to amendment,

subcl. (IX) read as follows: "subject to subsection (l)(4) of this section, who are described in subsection (l)(1) of this section;".

Subsec. (a)(10)(A)(ii)(X). Pub. L. 100-360, §301(e)(2)(A), struck out "subject to subsection (m)(3) of this section," before "who are described".

Subsec. (a)(10)(A)(ii)(XI). Pub. L. 100-360, §411(k)(5)(B), substituted "may be more restrictive" for "are more restrictive" and a semicolon for the period at end.

Pub. L. 100-360, §411(k)(5)(A), amended Pub. L. 100-203, §4104, see 1987 Amendment note below.

Subsec. (a)(10)(C)(i)(III). Pub. L. 100-360, §303(e)(1), substituted "no more restrictive than the methodology" for "the same methodology" in two places.

Subsec. (a)(10)(E). Pub. L. 100-360, §301(e)(2)(B), struck out "subject to subsection (m)(3) of this section;" before "for making medical".

Pub. L. 100-360, §301(a)(1), struck out "at the option of a State, but" after "(E)".

Subsec. (a)(13)(A). Pub. L. 100-360, §411(l)(3)(J), as added by Pub. L. 100-485, §608(d)(27)(H), amended Pub. L. 100-203, §4211(h)(2)(B), see 1987 Amendment note below.

Subsec. (a)(13)(C). Pub. L. 100-360, §411(l)(3)(H)(i), as amended by Pub. L. 100-485, §608(d)(27)(F), amended Pub. L. 100-203, §4211(h)(2)(C), see 1987 Amendment note below.

Subsec. (a)(13)(D). Pub. L. 100-360, §411(l)(3)(H)(ii), (iii), as amended by Pub. L. 100-485, §608(d)(27)(G), amended Pub. L. 100-203, §4211(h)(2)(D), see 1987 Amendment note below.

Subsec. (a)(15). Pub. L. 100-360, §301(e)(2)(C), as added by Pub. L. 100-485, §608(d)(14)(I)(iii), struck out par. (15) which read as follows: "in the case of eligible individuals 65 years of age or older who are not qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title) but are covered by either or both of the insurance programs established by subchapter XVIII of this chapter, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such subchapter is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;".

Subsec. (a)(17). Pub. L. 100-360, §411(k)(10)(G)(ii), amended directory language of Pub. L. 100-203, §4118(h)(1), see 1987 Amendment note below.

Pub. L. 100-360, §301(e)(2)(D), formerly §301(e)(2)(C), as redesignated and amended by Pub. L. 100-485, §608(d)(14)(I)(i), substituted "(m)(3), and (m)(4)" for "(m)(4), and (m)(5)".

Subsec. (a)(28)(D)(i). Pub. L. 100-360, §411(l)(3)(E), substituted "section 1396r(e) of this title" for "section 1396r(f) of this title (relating to implementation of nursing facility requirements, including paragraph (6)(E), relating to specification of resident assessment instrument)".

Subsec. (a)(33)(B). Pub. L. 100-360, §411(l)(6)(C), substituted "section 1396r(g) of this title" for "section 1396r(d) of this title".

Subsec. (a)(44)(A). Pub. L. 100-360, §411(l)(6)(D), amended Pub. L. 100-203, §4212(e)(1)(B), see 1987 Amendment note below.

Subsec. (a)(50). Pub. L. 100-360, §411(k)(4), formerly §411(h)(3), as redesignated by Pub. L. 100-485, §608(d)(28), added Pub. L. 100-203, §9119(d)(1)(A), see 1987 Amendment note below.

Subsec. (a)(51). Pub. L. 100-360, §303(e)(2)-(4), added par. (51).

Subsec. (a)(52). Pub. L. 100-485, §303(a)(2), added par. (52).

Subsec. (c). Pub. L. 100-360, §302(c)(1), amended subsec. (c) generally. Prior to amendment, subsec. (c) read as follows: "Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs) provided for eligible individuals under a plan of such State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter."

Subsec. (d). Pub. L. 100-360, §411(k)(7)(C), amended Pub. L. 100-203, §4113(b)(2)(ii), see 1987 Amendment note below.

Subsec. (e)(1). Pub. L. 100-485, §303(b)(1), designated existing provisions as subpar. (A), inserted "subject to subparagraph (B)" after "January 1, 1974,", and added subpar. (B).

Subsec. (e)(2)(A). Pub. L. 100-360, §411(k)(7)(D), repealed Pub. L. 100-203, §4113(d)(2), see 1987 Amendment note below.

Pub. L. 100-360, §411(k)(7)(B), amended Pub. L. 100-203, §4113(a)(2), see 1987 Amendment note below.

Subsec. (e)(6). Pub. L. 100-360, §302(e)(1), amended par. (6) generally. Prior to amendment, par. (6) read as follows: "At the option of a State, if a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX) of this section, the plan may provide that any woman described in such subsection and subsection (l)(1)(A) of this section shall continue to be treated as an individual described in subsection (a)(10)(A)(ii)(IX) of this section without regard to any change in income of the family of which she is a member until the end of the 60-day period beginning on the last day of her pregnancy."

Subsec. (e)(7). Pub. L. 100-360, §302(e)(2), in introductory provisions, substituted "In the case" for "If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX) of this section, in the case" and inserted "or paragraph (2) of section 1396d(n) of this title", and, in concluding provisions, substituted "such respective provision" for "subsection (a)(10)(A)(ii)(IX) of this section and subsection (l)(1) of this section".

Subsec. (e)(10). Pub. L. 100-485, §303(d), added par. (10).

Subsec. (f). Pub. L. 100-360, §411(k)(10)(G)(iv), added Pub. L. 100-203, §4118(h)(2), see 1987 Amendment note below.

Subsec. (i). Pub. L. 100-360, §411(l)(8)(C), amended Pub. L. 100-203, §4213(b)(1), see 1987 Amendment note below.

Subsec. (l)(1). Pub. L. 100-360, §302(e)(3)(A), inserted "any of subclauses (I) through (III) of" after "described in" in concluding provisions.

Subsec. (l)(1)(C). Pub. L. 100-360, §302(a)(2)(A), inserted "at the option of the State," after "(C)" and struck out "and" after "1983,".

Subsec. (l)(2)(A). Pub. L. 100-360, §302(a)(2)(B), as amended by Pub. L. 100-485, §608(d)(15)(A), designated existing provisions as cl. (i), substituted "(not less than the percentage provided under clause (ii) and not more than 185 percent)" for "(not more than 185 percent)", and added cls. (ii) and (iii).

Subsec. (l)(2)(A)(i). Pub. L. 100-485, §608(d)(15)(B)(i), in introductory provisions, substituted "The" for "Subject to clause (iii), the", and in subcl. (I), inserted "or, if greater, the percentage provided under clause (iii),".

Subsec. (l)(2)(A)(iii). Pub. L. 100-485, §608(d)(15)(B)(ii), substituted "clause (ii)(I)" for "clause (ii)" in introductory provisions and concluding provisions.

Subsec. (l)(3). Pub. L. 100-360, §302(e)(3)(B), inserted "(a)(10)(A)(i)((IV) or" after "of subsection" in introductory provisions.

Subsec. (l)(4). Pub. L. 100-360, §302(c)(2), (d), added par. (4) and struck out former par. (4) which read as follows:

"(A) A State plan may not elect the option of furnishing medical assistance to individuals described in subsection (a)(10)(A)(ii)(IX) of this section unless the State has in effect, under its plan established under part A of subchapter IV of this chapter, payment levels that are not less than the payment levels in effect under its plan on July 1, 1987.

"(B)(i) A State may not elect, under subsection (a)(10)(A)(ii)(IX) of this section, to cover only individuals described in paragraph (1)(A) or to cover only individuals described in paragraph (1)(B).

"(ii) A State may not elect, under subsection (a)(10)(A)(ii)(IX) of this section, to cover individuals described in subparagraph (C) of paragraph (1) unless the State has elected, under such subsection, to cover individuals described in the preceding subparagraphs of such paragraph.

"(C) A State plan may not provide, in its election of the option of furnishing medical assistance to individuals described in paragraph (1), that such individuals must apply for benefits under part A of subchapter IV of this chapter as a condition of applying for, or receiving, medical assistance under this subchapter."

Subsec. (m)(3). Pub. L. 100-360, §301(e)(2)(E), formerly §301(e)(2)(D), as redesignated and amended by Pub. L. 100-485, §608(d)(14)(I)(ii), redesignated par. (4) as (3), and struck out former par. (3) which read as follows: "A State plan may not provide coverage for individuals under subsection (a)(10)(A)(ii)(X) of this section or coverage under subsection (a)(10)(E) of this section, unless the plan provides coverage of some or all of the individuals described in subsection (l)(1) of this section."

Subsec. (m)(4). Pub. L. 100-360, §301(e)(2)(E), formerly §301(e)(2)(D), as redesignated and amended by Pub. L. 100-485, §608(d)(14)(I)(ii), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (m)(4)(A). Pub. L. 100-647, §8434(b)(2), substituted "section 1396d(p)(1)(B)" for "section 1396d(p)(1)(C)".

Subsec. (m)(5). Pub. L. 100-360, §301(e)(2)(E), formerly §301(e)(2)(D), as redesignated and amended by Pub. L. 100-485, §608(d)(14)(I)(ii), redesignated par. (5) as (4).

Subsec. (o). Pub. L. 100-360, §411(n)(2), made technical correction to directory language of Pub. L. 100-203, §9115(b), see 1987 Amendment note below.

Subsec. (q). Pub. L. 100-360, §411(n)(4), formerly §411(n)(3), as redesignated by Pub. L. 100-485, §608(d)(26), added Pub. L. 100-203, §9119(d)(1)(B), see 1987 Amendment note below.

Subsec. (r). Pub. L. 100-360, §303(e)(5), designated existing provisions as par. (1), redesignated subpars. (A) and (B) as cls. (i) and (ii), respectively, and added par. (2).

Pub. L. 100-360, §303(d), added subsec. (r).

Subsec. (r)(2)(A). Pub. L. 100-485, §608(d)(16)(C), substituted ", or (f) of this section or under section 1396d(p) of this title" for "of this section, or under subsection (f) of this section" in introductory provisions.

1987—Subsec. (a)(9)(C). Pub. L. 100-203, §4072(d), substituted "paragraphs (13) and (14)" for "paragraphs (12) and (13)".

Subsec. (a)(10). Pub. L. 100-203, §4101(e)(1), substituted "postpartum, and family planning services" for "and postpartum services" in subdiv. (VII) of closing provisions.

Subsec. (a)(10)(A)(ii)(VI). Pub. L. 100-203, §4211(h)(1)(A), substituted "nursing facility or intermediate care facility for the mentally retarded" for "skilled nursing facility or intermediate care facility".

Pub. L. 100-203, §4102(b)(1), substituted "subsection (c) or (d) of section 1396n of this title" for "section 1396n(c) of this title" in two places.

Subsec. (a)(10)(A)(ii)(IX), (X). Pub. L. 100-203, §4118(p)(1), (3), realigned margin of subcls. (IX) and (X).

Subsec. (a)(10)(A)(ii)(XI). Pub. L. 100-203, §4104, as amended by Pub. L. 100-360, §411(k)(5)(A), added subcl. (XI).

Subsec. (a)(10)(C)(iv). Pub. L. 100-203, §4211(h)(1)(B), substituted "in an intermediate care facility" for "intermediate care facility services".

Subsec. (a)(10)(D). Pub. L. 100-203, §4211(h)(1)(C), struck out "skilled" before "nursing".

Subsec. (a)(13)(A). Pub. L. 100-203, §4211(h)(2)(B), as amended by Pub. L. 100-360, §411(f)(3)(J), as added by Pub. L. 100-485, §608(d)(27)(H), substituted ", nursing facility, and intermediate care facility for the mentally retarded and" for ", skilled nursing facility, and intermediate care facility and".

Pub. L. 100-203, §4211(h)(2)(A), substituted "services, nursing facility services, and services in an intermediate care facility for the mentally retarded" for ", skilled nursing facility, and intermediate care facility services".

Pub. L. 100-203, §4211(b)(1)(A), inserted "which, in the case of nursing facilities, take into account the costs of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care;" after second reference to "State".

Subsec. (a)(13)(C). Pub. L. 100-203, §4211(b)(2)(C), as amended by Pub. L. 100-360, §411(f)(3)(H)(i), as amended by Pub. L. 100-485, §608(d)(27)(F), substituted "nursing facilities and for intermediate care facilities for the mentally retarded" for "skilled nursing facilities and intermediate care facilities" in introductory provisions.

Subsec. (a)(13)(D). Pub. L. 100-203, §4211(h)(2)(D), as amended by Pub. L. 100-360, §411(f)(3)(H)(ii), (iii), as amended by Pub. L. 100-485, §608(d)(27)(G), substituted "nursing facility or intermediate care facility for the mentally retarded" for "skilled nursing facility or intermediate care facility" and "nursing facility services or services in an intermediate care facility for the mentally retarded" for "skilled nursing facility services or intermediate care facility services".

Subsec. (a)(17). Pub. L. 100-203, §4118(p)(3), substituted "subsections (f)(3), (m)(4), and (m)(5) of this section" for "subsection (f)(3) of this section".

Pub. L. 100-203, §4118(h)(1), as amended by Pub. L. 100-360, §411(k)(10)(C)(ii), substituted "(whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof)" for "(whether in the form of insurance premiums or otherwise)".

Subsec. (a)(23). Pub. L. 100-203, §4113(c)(1), designated provision relating to the obtaining of medical assistance by an eligible individual as cl. (A) and added cl. (B).

Pub. L. 100-93, §8(f)(1), inserted "subsection (g) of this section and in" after "as provided in".

Subsec. (a)(28). Pub. L. 100-203, §4211(b)(1)(B), amended par. (28) generally. Prior to amendment, par. (28) read as follows: "provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x(j) of this title, except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases shall not apply for purposes of this subchapter;".

Subsec. (a)(30)(B)(i), (ii). Pub. L. 100-203, §4211(h)(3), substituted "intermediate care facility for the mentally retarded" for "skilled nursing facility, intermediate care facility".

Subsec. (a)(30)(C). Pub. L. 100-203, §4118(p)(4), substituted "use" for "provide".

Pub. L. 100-203, §4118(b)(1), inserted ", an entity which meets the requirements of section 1320c-1 of this title, as determined by the Secretary," before "or a private accreditation body".

Subsec. (a)(31). Pub. L. 100-203, §4212(d)(2), in introductory provision substituted "services in an intermediate care facility for the mentally retarded (where" for "skilled nursing facility services (and with respect to intermediate care facility services where" and in subpar. (B) substituted "intermediate care facility for the mentally retarded" for "skilled nursing or intermediate care facility".

Subsec. (a)(33)(B). Pub. L. 100-203, §4212(d)(3), inserted ", except as provided in section 1396r(d) of this title," after "(B) that".

Subsec. (a)(38). Pub. L. 100-93, §8(f)(2), substituted "the information described in section 1320a-7(b)(9) of this title" for "respectively, (A) full and complete information as to the ownership of a subcontractor (as

defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor".

Subsec. (a)(39). Pub. L. 100-93, §8(f)(3), substituted "exclude" for "bar", "individual or entity" for "person" in two places, and inserted reference to section 1320a-7a of this title.

Subsec. (a)(42). Pub. L. 100-203, §4118(m)(1)(B), struck out "(A)" after "provide", the comma after "under the plan", and cls. (B) and (C) which read as follows: "(B) that such audits, for such entities also providing services under subchapter XVIII of this chapter, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such subchapter, and (C) for payment of such proportion of costs of such such common audit as is determined under methods specified by the Secretary under section 1320a-3(a) of this title".

Subsec. (a)(44). Pub. L. 100-203, §4212(e)(1)(A), substituted "services in an intermediate care facility for the mentally retarded" for "skilled nursing facility services, intermediate care facility services".

Subsec. (a)(44)(A). Pub. L. 100-203, §4216(a)(1), substituted "physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies" for "physician certifies" and "a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician," for "the physician, or a physician assistant or nurse practitioner under the supervision of a physician,".

Pub. L. 100-203, §4212(e)(1)(B), as amended by Pub. L. 100-360, §411(l)(6)(D), substituted "that are services provided in an intermediate care facility for the mentally retarded" for "that are intermediate care facility services provided in an institution for the mentally retarded".

Subsec. (a)(44)(B). Pub. L. 100-203, §4216(a)(2), substituted "a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;" for "a physician;".

Subsec. (a)(46). Pub. L. 100-93, §5(a)(1), struck out "and" after "title;".

Subsec. (a)(47). Pub. L. 100-93, §5(a)(2), (3), substituted semicolon for period at end of par. (47), relating to ambulatory prenatal care and redesignated par. (47), relating to cards evidencing eligibility, as (48).

Subsec. (a)(48). Pub. L. 100-93, §5(a)(3), redesignated par. (47), relating to cards evidencing eligibility for medical assistance, as (48), and substituted "address; and" for "address,".

Subsec. (a)(49). Pub. L. 100-93, §5(a)(4), added par. (49).

Subsec. (a)(50). Pub. L. 100-203, §9119(d)(1)(A), as added by Pub. L. 100-360, §411(n)(4), formerly §411(n)(3), as redesignated by Pub. L. 100-485, §608(d)(26), added par. (50).

Subsec. (d). Pub. L. 100-203, §4113(b)(2)(i), inserted "an entity which meets the requirements of section 1320c-1 of this title, as determined by the Secretary, for the performance of the quality review functions described in subsection (a)(30)(C) of this section, or" after "contracts with".

Pub. L. 100-203, §4113(b)(2)(ii), as amended by Pub. L. 100-360, §411(k)(7)(C), substituted "an entity or organization" for "organization (or organizations)" in two places.

Subsec. (e)(2)(A). Pub. L. 100-203, §4113(d)(2), which directed substitution of "subparagraph (B)(iii), (E), or (G) of section 1396b(m)(2) of this title" for "section 1396a(m)(2)(G) of this title", was repealed by Pub. L. 100-360, §411(k)(7)(D).

Pub. L. 100-203, §4113(a)(2), as amended by Pub. L. 100-360, §411(k)(7)(B), substituted "paragraph (2)(B)(iii), (2)(E), (2)(G), or (5) of section 1396b(m) of this title" for "section 1396b(m)(2)(G) of this title".

Pub. L. 100-203, §4113(c)(2), substituted "but, except for benefits furnished under section 1396d(a)(4)(C) of this title, only" for "but only".

Subsec. (e)(3)(B)(i). Pub. L. 100-203, §4211(h)(4), substituted "nursing facility, or intermediate care facility for the mentally retarded" for "skilled nursing facility, or intermediate care facility".

Subsec. (e)(3)(C). Pub. L. 100-203, §4118(c)(1), substituted "for medical assistance under the State plan under this subchapter" for "to have a supplemental security income (or State supplemental) payment made with respect to him under subchapter XVI of this chapter".

Subsec. (e)(4). Pub. L. 100-203, §4101(a)(2), inserted sentence at end relating to child's medical assistance eligibility identification number and submission and payment of claims under such number during period in which a child is eligible for assistance.

Subsec. (e)(5). Pub. L. 100-203, §4101(e)(2), substituted "through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends" for "until the end of the 60-day period beginning on the last day of her pregnancy".

Subsec. (e)(7). Pub. L. 100-203, §4101(b)(2)(B), substituted "subparagraph (B) or (C)" for "subparagraph (B), (C), (D), (E), or (F)".

Subsec. (e)(9). Pub. L. 100-203, §4118(g)(6), realigned margins of par. (9).

Subsec. (e)(9)(A)(iii). Pub. L. 100-203, §4211(h)(5)(A), substituted "nursing facility, or intermediate care facility for the mentally retarded" for "skilled nursing facility, or intermediate care facility,".

Subsec. (e)(9)(B). Pub. L. 100-203, §4211(h)(5)(B), substituted "nursing facilities, or intermediate care facilities for the mentally retarded" for "skilled nursing facilities, or intermediate care facilities".

Subsec. (f). Pub. L. 100-203, §4118(h)(2), as added by Pub. L. 100-360, §411(k)(10)(G)(iv), inserted "regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof" after "State law" in first sentence.

Subsec. (i). Pub. L. 100-203, §4213(b)(1), as amended by Pub. L. 100-360, §411(l)(8)(C), in par. (1), substituted "intermediate care facility for the mentally retarded" for "skilled nursing facility or intermediate care facility" and "the requirements for such a facility under this subchapter" for "the provisions of section 1395x(j) of this title or section 1396d(o) of this title, respectively.", and in pars. (2) and (3), substituted "the requirements for such a facility under this subchapter" for "the provisions of section 1395x(j) of this title or section 1396d(o) of this title (as the case may be)".

Subsec. (j). Pub. L. 100-203, §4116, inserted reference to Northern Mariana Islands in two places.

Subsec. (l). Pub. L. 100-93, §7, redesignated subsec. (l), relating to disregarding certain benefits for purposes of determining post-eligibility contributions, as (o).

Subsec. (l)(1). Pub. L. 100-203, §4118(p)(7), made technical corrections in introductory provisions and substituted "and whose" for ", whose" in closing provisions.

Subsec. (l)(1)(C). Pub. L. 100-203, §4101(c)(2), substituted "5, 6, 7, or 8 years of age" for "or 5 years of age".

Pub. L. 100-203, §4101(b)(1), added subpar. (C). Former subpar. (C), which related to children who have attained one year of age but have not attained two years of age, was struck out.

Subsec. (l)(1)(D) to (F). Pub. L. 100-203, §4101(b)(1)(B), struck out subpars. (D) to (F) which related to children

who have attained two years of age but have not attained three years of age, children who have attained three years of age but have not attained four years of age, and children who have attained four years of age but have not attained five years of age, respectively.

Subsec. (*l*)(2). Pub. L. 100-203, §4118(p)(3), struck out "nonfarm" after second reference to "income" in subpar. (A).

Pub. L. 100-203, §4101(a)(1)(A), designated existing provisions as subpar. (A), inserted "with respect to individuals described in subparagraph (A) or (B) of that paragraph", substituted "185 percent" for "100 percent", and added subpar. (B).

Subsec. (*l*)(3)(C). Pub. L. 100-203, §4101(b)(2)(A)(i), substituted "subparagraph (B) or (C)" for "subparagraph (B), (C), (D), (E), or (F)".

Subsec. (*l*)(3)(D). Pub. L. 100-203, §4101(a)(1)(B), inserted "appropriate" after "applied is the".

Subsec. (*l*)(3)(E). Pub. L. 100-203, §4101(c)(3), inserted "(except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17) of this section)" after "subchapter IV of this chapter".

Subsec. (*l*)(4)(A). Pub. L. 100-203, §4101(a)(4), substituted "July 1, 1987" for "April 1, 1986".

Subsec. (*l*)(4)(B)(ii). Pub. L. 100-203, §4101(b)(2)(A)(ii), substituted "subparagraph (C)" for "subparagraph (C), (D), (E), or (F)".

Subsec. (*l*)(4)(C). Pub. L. 100-203, §4101(c)(5), added subpar. (C).

Subsec. (m)(2)(A). Pub. L. 100-203, §4118(p)(3), struck out "nonfarm" before "official".

Subsec. (*o*). Pub. L. 100-203, §9115(b), as amended by Pub. L. 100-360, §411(n)(2), substituted "subparagraph (E) or (G) of section 1382(e)(1) of this title" for "section 1382(e)(1)(E) of this title".

Pub. L. 100-93, §7, redesignated subsec. (*l*), relating to disregarding certain benefits for purposes of determining post-eligibility contributions, as (*o*).

Subsec. (*p*). Pub. L. 100-93, §7, added subsec. (*p*).

Subsec. (*q*). Pub. L. 100-203, §9119(d)(1)(B), as added by Pub. L. 100-360, §411(n)(4), formerly §411(n)(3), as redesignated by Pub. L. 100-485, §608(d)(28), added subsec. (*q*).

1985—Subsec. (a). Pub. L. 99-509, §9406(b), inserted at end "Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1395b(v) of this title."

Pub. L. 98-272, §9529(a)(1), inserted at end "For purposes of this subchapter, any child who meets the requirements of paragraph (1) or (2) of section 673(b) of this title shall be deemed to be a dependent child as defined in section 606 of this title and shall be deemed to be a recipient of aid to families with dependent children under part A of subchapter IV of this chapter in the State where such child resides."

Subsec. (a)(9)(C). Pub. L. 99-509, §9320(b)(3), substituted "paragraphs (12) and (13)" for "paragraphs (11) and (12)".

Subsec. (a)(10). Pub. L. 99-509, §9408(b), added cl. (IX) at end.

Pub. L. 99-509, §9403(c), added cl. (VIII) at end.

Pub. L. 99-509, §9401(c), added cl. (VII) at end.

Pub. L. 98-272, §9505(b)(1), added cl. (VI) at end.

Pub. L. 98-272, §9501(b), added cl. (V) at end.

Subsec. (a)(10)(A)(i)(I). Pub. L. 99-272, §12305(b)(3), substituted ", 606(h), or 673(b) of this title" for "or 606(h) of this title".

Subsec. (a)(10)(A)(i)(II). Pub. L. 99-509, §9404(a), inserted "or who are qualified severely impaired individuals (as defined in section 1396d(q) of this title)" after "subchapter XVI of this chapter".

Subsec. (a)(10)(A)(ii)(V). Pub. L. 99-272, §9510(a), inserted "for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period)" after "are in a medical institution".

Subsec. (a)(10)(A)(ii)(VII). Pub. L. 99-514, §1895(c)(7)(A), realigned margin of subcl. (VII).

Pub. L. 99-272, §9505(b)(2), added subcl. (VII).

Subsec. (a)(10)(A)(ii)(VIII). Pub. L. 99-514, §1895(c)(7)(B), realigned margins of subcl. (VIII).

Pub. L. 99-272, §9529(b)(1), added subcl. (VIII).

Subsec. (a)(10)(A)(ii)(IX). Pub. L. 99-509, §9401(a), added subcl. (IX).

Subsec. (a)(10)(A)(ii)(X). Pub. L. 99-509, §9402(a)(1), added subcl. (X).

Subsec. (a)(10)(C). Pub. L. 99-509, §9403(g)(1), inserted "or (E)" after "subparagraph (A)" in introductory text.

Subsec. (a)(10)(C)(iv). Pub. L. 99-509, §9408(c)(3), substituted "through (20)" for "through (19)".

Pub. L. 99-514, §1895(c)(3)(C), substituted "through (19)" for "through (18)".

Pub. L. 99-272, §9505(d)(2), substituted "through (18)" for "through (17)".

Subsec. (a)(10)(E). Pub. L. 99-509, §9403(a), added subpar. (E).

Subsec. (a)(13)(B). Pub. L. 99-272, §9509(a)(1), substituted "hospitals" for "hospitals, skilled nursing facilities, and intermediate care facilities".

Subsec. (a)(13)(C). Pub. L. 99-272, §9509(a)(4), added subpar. (C). Former subpar. (C) redesignated (D).

Pub. L. 99-272, §9505(c)(1), added subpar. (C). Former subpar. (C) redesignated (D).

Subsec. (a)(13)(D). Pub. L. 99-514, §1895(c)(1), inserted "and" after "facility;".

Pub. L. 99-509, §9435(b)(1), inserted "and for payment of amounts under section 1396d(o)(3) of this title" before first semicolon.

Pub. L. 99-272, §9509(a)(2), (3), redesignated former subpar. (C) as (D), and struck out "and" at the end thereof. Former subpar. (D) redesignated (E).

Pub. L. 99-272, §9505(c)(1)(B), redesignated former subpar. (C) as (D).

Subsec. (a)(13)(E). Pub. L. 99-272, §9509(a)(3), redesignated former subpar. (D) as (E).

Subsec. (a)(15). Pub. L. 99-509, §9403(g)(4)(A), inserted "are not qualified medicare beneficiaries (as defined in section 1396d(p)(1) of this title) but" after "older who".

Subsec. (a)(17). Pub. L. 99-509, §9401(e)(1), inserted "except as provided in subsection (*l*)(3) of this section" after "(17)".

Subsec. (a)(25). Pub. L. 99-272, §9503(a)(1), amended par. (25) generally. Prior to amendment, par. (25) read as follows: "provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17)(B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;".

Subsec. (a)(30)(C). Pub. L. 99-509, §9431(a), added subpar. (C).

Subsec. (a)(47). Pub. L. 99-670 added par. (47) relating to cards evidencing eligibility for medical assistance.

Pub. L. 99-509, §9407(a), added par. (47) relating to ambulatory prenatal care.

Subsec. (b)(2). Pub. L. 99-509, §9405, inserted before semicolon ", regardless of whether or not the residence is maintained permanently or at a fixed address".

Subsec. (d). Pub. L. 99-509, §9431(b)(1), inserted "(including quality review functions described in subsection (a)(30)(C) of this section)" after "medical or utilization review functions".

Subsec. (e)(2)(A). Pub. L. 99-272, §9517(b)(1), inserted reference to an entity described in section 1396b(m)(3)(G) of this title, and substituted "such organization or entity" for "such organization".

Subsec. (e)(2)(B). Pub. L. 99-272, §9517(b)(2), substituted "an organization or entity" for "a health

maintenance organization" and "the organization or entity" for "the organization".

Subsec. (e)(5). Pub. L. 99-272, § 9501(c), added par. (5).

Subsec. (e)(6), (7). Pub. L. 99-509, § 9401(d), added pars. (6) and (7).

Subsec. (e)(8). Pub. L. 99-509, § 9403(f)(2), added par. (8).

Subsec. (e)(9). Pub. L. 99-509, § 9408(a), added par. (9).

Subsec. (f). Pub. L. 99-643, § 7(b), substituted "subsection (e) of this section and section 1382h(b)(3) of this title" for "subsection (a) of this section".

Subsec. (g). Pub. L. 99-272, § 9503(a)(2), added subsec. (g).

Subsec. (h). Pub. L. 99-509, § 9433(a), added subsec. (d) to section 2173 of Pub. L. 97-35 in turn which added subsec. (h) of this section. See 1991 Amendment note below.

Subsec. (j). Pub. L. 99-509, § 9408(c)(2), substituted "(21)" for "(20)".

Pub. L. 99-514, § 1838(c)(3)(B), substituted "(20)" for "(19)".

Pub. L. 99-272, § 9505(d)(1), substituted "(19)" for "(18)".

Subsec. (k). Pub. L. 99-272, § 9506(a), added subsec. (k).

Subsec. (l). Pub. L. 99-643, § 3(b), added subsec. (l) relating to disregarding of certain benefits for purposes of determining post-eligibility contributions.

Pub. L. 99-509, § 9401(b), added subsec. (l) relating to description of group.

Subsec. (m). Pub. L. 99-509, § 9402(a)(2), (b), added subsec. (m).

Subsec. (m)(3). Pub. L. 99-509, § 9403(f)(1)(A), which directed insertion of "or coverage under subsection (a)(10)(E) of this section" after "subsection (a)(10)(A)(ii)(IX) of this section", was executed by making the insertion after "subsection (a)(10)(A)(ii)(X) of this section" as the probable intent of Congress.

Subsec. (m)(5). Pub. L. 99-509, § 9403(f)(1)(B), added par. (5).

Subsec. (n). Pub. L. 99-509, § 9403(e), added subsec. (n).

1984—Subsec. (a)(9)(C). Pub. L. 98-369, § 2373(b)(1), realigned margin of subpar. (C).

Subsec. (a)(10)(A). Pub. L. 98-369, § 2373(b)(2), realigned margins of subpar. (A).

Subsec. (a)(10)(A)(i). Pub. L. 98-369, § 2361(a), amended cl. (i) generally. Prior to the amendment cl. (i) read as follows: "all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized in section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title), or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter; and".

Subsec. (a)(10)(A)(i)(I). Pub. L. 98-378, § 20(c), substituted "section 602(a)(37) or 606(h) of this title" for "section 602(a)(37) of this title".

Subsec. (a)(13)(A). Pub. L. 98-369, § 2373(b)(3), made clarifying amendment by striking out "(A)" and all that follows through "hospital" the first place it appears and inserting in lieu thereof "(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital", resulting in no change in text.

Subsec. (a)(13)(B), (C). Pub. L. 98-369, § 2314(b), added subpar. (B) and redesignated former subpar. (B) as (C).

Subsec. (a)(20)(B). Pub. L. 98-369, § 2373(b)(4), substituted "periodic" for "periodical".

Subsec. (a)(20)(C). Pub. L. 98-369, § 2373(b)(5), struck out reference to section 603(a)(1)(A)(i) and (ii) of this title.

Subsec. (a)(26). Pub. L. 98-369, § 2368(b), in amending par. (26) generally, revised existing provisions to continue their application to review of inpatient mental hospital service programs, and to sever provisions relating to review of skilled nursing programs. See par. (31) of this section.

Subsec. (a)(26)(B)(ii). Pub. L. 98-617, § 3(a)(7), repealed the amendment made by Pub. L. 98-369, § 2373(b)(6). See below.

Pub. L. 98-369, § 2373(b)(6), provided that cl. (ii) is amended by substituting "facilities" for "homes".

Subsec. (a)(26)(C). Pub. L. 98-617, § 3(b)(10), realigned margin of subpar. (C).

Subsec. (a)(28). Pub. L. 98-369, § 2335(a), struck out "and tuberculosis" after "mental diseases".

Subsec. (a)(30). Pub. L. 98-369, § 2363(a)(1)(A), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(31). Pub. L. 98-369, § 2368(a), in amending par. (31) generally, revised existing provisions to cover review of skilled nursing facilities.

Subsec. (a)(33)(A). Pub. L. 98-369, § 2373(b)(7), substituted "second sentence" for "penultimate sentence".

Subsec. (a)(42). Pub. L. 98-369, § 2373(b)(8), substituted "subchapter" for "part" after "audits conducted for purposes of such".

Subsec. (a)(43). Pub. L. 98-369, § 2303(g)(1), redesignated par. (44) as (43), and struck out former par. (43) which provided that if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician, or other physician with whom he shares his practice, did not personally perform or supervise, the plan include provision to insure that payment for such services not exceed the payment authorized by section 1395u(h) of this title.

Subsec. (a)(44). Pub. L. 98-369, § 2363(a)(1)(B), added par. (44).

Pub. L. 98-369, § 2303(g)(1)(C), redesignated former par. (44) as (43).

Subsec. (a)(45). Pub. L. 98-369, § 2367(a), added par. (45).

Subsec. (a)(46). Pub. L. 98-369, § 2651(c), added par. (46).

Subsec. (a), foll. par. (46). Pub. L. 98-369, § 2373(b)(9), substituted "The provisions of paragraph (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to" for "For purposes of paragraph (9)(A), (26), (31), and (33), and of section 1396b(i)(4) of this title, the term 'skilled nursing facility' and 'nursing home' do not include".

Subsec. (c)(4). Pub. L. 98-369, § 2362(a), added par. (4).

Subsec. (f). Pub. L. 98-369, § 2373(b)(10), substituted "paragraph (10)(A)" and "paragraph (10)(C)" for "clause (10)(A)" and "clause (10)(C)", respectively, wherever appearing.

1982—Subsec. (a)(10). Pub. L. 97-248, § 131(c), formerly § 131(b), as redesignated by Pub. L. 97-448, § 309(a)(6), in provisions following subpar. (D) added cl. (IV).

Subsec. (a)(10)(A). Pub. L. 97-248, § 137(b)(7), redesignated existing provisions as provisions preceding cl. (i) and cl. (j), and added cl. (ii).

Subsec. (a)(10)(C), (D). Pub. L. 97-248, § 137(a)(3), amended directory language of Pub. L. 97-35, § 2171(a)(3), to correct an error, and did not involve any change in text. See 1981 Amendment note below.

Subsec. (a)(10)(C)(i). Pub. L. 97-248, § 137(b)(8), substituted ", (II)" for "and (II)", and added subcl. (III).

Subsec. (a)(10)(C)(ii)(I). Pub. L. 97-248, § 137(b)(9), substituted "under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i)" for "described in section 1396d(a)(i) of this title".

Subsec. (a)(14). Pub. L. 97-248, § 131(a), substituted provisions that a State plan for medical assistance must provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1396o of this title for provisions that such plan must provide that, with respect to individuals receiving assistance, no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in pars. (1) through (5), (7), and (17) of section 1396d(a) of this title, would be imposed under the plan, and any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services would be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and with respect to individuals not receiving assistance, there could be imposed an enrollment fee, premium, or similar charge (as determined in ac-

cordance with standards prescribed by the Secretary) related to the individual's income, and any deductible, cost-sharing, or similar charge imposed under the plan would be nominal.

Subsec. (a)(18). Pub. L. 97-248, §132(a), substituted provisions that a State plan for medical assistance must comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid, and transfers of assets for provisions that such plan must provide that no lien could be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there would be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he had no surviving child who was under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), was blind or permanently and totally disabled, or was blind or disabled as defined in section 1382c of this title with respect to States which were not eligible to participate in such program) of any medical assistance correctly paid on behalf of such individual under the plan.

Subsec. (a). Pub. L. 97-248, §137(e), inserted ", (26)" after "(9)(A)" in provisions following par. (44).

Subsec. (b)(2) to (4). Pub. L. 97-248, §137(b)(10), struck out par. (2) which provided that the Secretary would not approve any plan which imposed any age requirement which excluded any individual who had not attained the age of 19 and was a dependent child under part A of subchapter IV of this chapter, and redesignated paras. (3) and (4) as (2) and (3), respectively.

Subsec. (d). Pub. L. 97-248, §146(a), substituted references to utilization and quality control peer review organizations having a contract with the Secretary, for references to conditionally or otherwise designated Professional Standards Review Organizations, wherever appearing.

Subsec. (e)(3). Pub. L. 97-248, §134(a), added par. (3).

Subsec. (j). Pub. L. 97-248, §§132(c), 136(d), struck out subsec. (j) which related to the denial of medical assistance under a State plan because of an individual's disposal of resources for less than fair market value, the period of ineligibility, and the eligibility of certain individuals for medical assistance under a State plan who would otherwise be ineligible because of the provisions of section 1382b(c) of this title, and added a new subsec. (j) relating to waiver or modification of requirements with respect to American Samoa medical assistance program.

1981—Subsec. (a)(9)(C). Pub. L. 97-35, §2175(d)(1)(C), added subpar. (C).

Subsec. (a)(10)(A). Pub. L. 97-35, §2171(a)(1), substituted "including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized by section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title)" for "to all individuals receiving aid or assistance under any plan of the State approved under subchapters I, X, XIV, or XVI, or part A of subchapter IV of this chapter".

Subsec. (a)(10)(B). Pub. L. 97-35, §2171(a)(2), substituted reference to subparagraph for reference to clause in two places.

Subsec. (a)(10)(C). Pub. L. 97-35, §2171(a)(3), as amended by Pub. L. 97-248, §137(a)(3), substituted provisions relating to plans for medical assistance included for any group of individuals described in section 1396d(a) of this title who are not described in subpar. (A) for provisions relating to medical assistance for any group of individuals not described in subpar. (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplementary security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary.

Subsec. (a)(10)(D). Pub. L. 97-35, §2171(a)(3), as amended by Pub. L. 97-248, §137(a)(3), added subpar. (D).

Subsec. (a)(11). Pub. L. 97-35, §2193(c)(9), substituted "under or through an allotment under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment" for "for part or all of the cost of plans or projects under subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under subchapter V of this chapter".

Subsec. (a)(13)(A). Pub. L. 97-35, §§2171(b), 2173(a)(1)(B), (C), struck out subpar. (A) which provided that a State plan must provide for the inclusion of some institutional and some noninstitutional care and services and for the inclusion of home health services for any individual who is entitled to skilled nursing facility services, redesignated subpar. (E) as (A), and in subpar. (A), as so redesignated, made the subsection applicable to hospital facilities, inserted reference to rates which take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care under conditions similar to those described in section 1395x(v)(1)(G) of this title, for lower reimbursement rates reflecting the level of care actually received in a manner consistent with such section, and substituted "safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality" for "safety standards".

Subsec. (a)(13)(B). Pub. L. 97-35, §§2171(b), 2179(a)(1)(C), struck out subpar. (B) which provided that a State plan must provide in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, for the inclusion of at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, and redesignated subpar. (F) as (B).

Subsec. (a)(13)(C). Pub. L. 97-35, §2171(b), struck out subpar. (C) which provided for care and services of individuals not included in former subpar. (B).

Subsec. (a)(13)(D). Pub. L. 97-35, §2178(a)(1)(A), struck out subpar. (D) which provided for payment of reasonable cost of inpatient hospital services provided under the plan with provisions for determination of such costs with certain maximum limitations and for payment of reasonable cost of inappropriate inpatient services described in subsec. (h)(1) of this section.

Subsec. (a)(13)(E), (F). Pub. L. 97-35, §2173(a)(1)(C), redesignated subpars. (E) and (F) as (A) and (B), respectively.

Subsec. (a)(20)(D). Pub. L. 97-35, §2173(a)(2), struck out subpar. (D) which required provision for methods of determining reasonable cost of institutional care of such patients.

Subsec. (a)(23). Pub. L. 97-35, §2175(a), substituted "except as provided in section 1396a and except in the case of" for "except in the case of", and struck out provision that a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or pars. (1) and (10) of this subsection solely by reason of the fact that the State or any political subdivision thereof has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to indi-

viduals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic.

Subsec. (a)(25)(C). Pub. L. 97-35, §2182, substituted "of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State" for "of the individual, the State".

Subsec. (a)(30). Pub. L. 97-35, §2174(a), substituted "that payments are consistent" for "that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent".

Subsec. (a)(39). Pub. L. 97-35, §2105(c), substituted "person" for "individual" in two places.

Subsec. (a)(44). Pub. L. 97-35, §2181(a)(2)(C), added par. (44).

Subsec. (b)(2). Pub. L. 97-35, §2172(a), substituted "any age requirement which excludes any individual who has not attained the age of 19 and is a dependent child under part A of subchapter IV of this chapter;" for "effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 606(a)(2) of this title, be a dependent child under part A of subchapter IV of this chapter; or".

Subsec. (d). Pub. L. 97-35, §2113(m), added subsec. (d).

Subsec. (e). Pub. L. 97-35, §2178(b), designated existing provisions as par. (1) and added par. (2).

Subsec. (h). Pub. L. 97-35, §2173(b)(1), (d), as amended by Pub. L. 99-509, §9433(a), added a new subsec. (h) and repealed former subsec. (h) which related to skilled nursing and intermediate care facility services.

1980—Subsec. (a)(13)(B). Pub. L. 96-499, §965(b)(1), substituted "paragraphs (1) through (5) and (17)" for "clauses (1) through (5)".

Subsec. (a)(13)(C)(i). Pub. L. 96-499, §965(b)(2), substituted "paragraphs (1) through (5) and (17)" for "clauses (1) through (5)".

Subsec. (a)(13)(C)(ii). Pub. L. 96-499, §965(b)(3), substituted "paragraphs numbered (1) through (17)" for "clauses numbered (1) through (16)".

Subsec. (a)(13)(D). Pub. L. 96-499, §902(b)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(13)(D)(i). Pub. L. 96-499, §§903(b), 905(a), inserted "(except where the State agency is subject to an order under section 1396m of this title)" after "payment" and ", except that in the case of hospitals reimbursed for services under part A of subchapter XVIII of this chapter in accordance with section 1395f(b)(3) of this title, the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section" after "subchapter XVIII of this chapter".

Subsec. (a)(13)(E). Pub. L. 96-499, §905(a), inserted "(except where the State agency is subject to an order under section 1396m of this title)".

Pub. L. 96-499, §962(a), substituted provisions which required a State plan for medical assistance to provide for payment of skilled nursing facility and intermediate care facility services provided under such plan through the use of rates determined in accordance with methods and standards developed by the State rather than on a reasonable cost related basis, required the filing of uniform cost reports by each facility, and required periodic audits of such reports by the State.

Subsec. (a)(14)(A)(i). Pub. L. 96-499, §965(b)(4), substituted "paragraphs (1) through (5), (7), and (17)" for "clauses (1) through (5) and (7)".

Subsec. (a)(33)(B). Pub. L. 96-499, §916(b)(1)(B), inserted exception authorizing the Secretary where there was cause to question the adequacy of participation determinations to make independent determinations concerning the extent to which individual institutions and agencies met the requirements for participation.

Subsec. (a)(35). Pub. L. 96-499, §912(b), substituted "disclosing entity (as defined in section 1320a-3(a)(2) of this title)" for "intermediate care facility".

Subsec. (a)(39). Pub. L. 96-499, §913(c), substituted provisions requiring that State plans for medical assistance authorize the State agency to bar specified individuals from participation in the program under the State plan when required by the Secretary to do so pursuant to section 1320a-7 of this title for provisions requiring that State plans for medical assistance provide for the suspension of physicians or other individuals from participation in the State plan upon notification by the Secretary that such physician or other individual had been suspended from participation in the plan under subchapter XVIII of this chapter.

Subsec. (a)(41). Pub. L. 96-272 added par. (41).

Subsec. (a)(42). Pub. L. 96-499, §914(b)(1), added par. (42).

Subsec. (a)(43). Pub. L. 96-499, §918(b)(1)(C), added par. (43).

Subsec. (g). Pub. L. 96-499, §913(d), struck out subsec. (g) which related to waiver of suspension of payments to physicians or practitioners suspended from participation in approved State plans.

Subsec. (h). Pub. L. 96-499, §902(b)(2), added subsec. (h).

Subsec. (i). Pub. L. 96-499, §916(b)(1)(A), added subsec. (i).

Subsec. (j). Pub. L. 96-611 added subsec. (j).

1978—Subsec. (a)(4)(C). Pub. L. 95-559 added cl. (C).

1977—Subsec. (a)(13)(F). Pub. L. 95-210, §2(c)(1), added subpar. (F).

Subsec. (a)(23). Pub. L. 95-210, §2(c)(2), inserted ", or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic" after "who elect to obtain such care and services from such organization".

Subsec. (a)(26). Pub. L. 95-142, §2(b), inserted provision relating to staff of skilled nursing facilities.

Subsec. (a)(27)(B). Pub. L. 95-142, §9, inserted "or the Secretary" after "State agency" wherever appearing.

Subsec. (a)(32). Pub. L. 95-142, §2(a)(3), substituted provisions relating to terms, conditions, etc., for payments under an assignment or power of attorney, for provisions relating to terms, conditions, etc., for payments to anyone other than the individual receiving any care or service provided by a physician, dentist, or other individual practitioner, or such physician, dentist, or practitioner.

Subsec. (a)(35). Pub. L. 95-142, §3(c)(1)(A), substituted provisions relating to requirements for intermediate care facilities to comply with section 1320a-3 of this title for provisions relating to disclosure requirements, effective Jan. 1, 1973, applicable to intermediate care facilities with respect to ownership, corporate, status, etc.

Subsec. (a)(37). Pub. L. 95-142, §§2(b)(1)(C), 3(c)(1)(C), 7(b)(1), added subsec. (a)(37) and made and struck out minor changes in phraseology, necessitating no changes in text.

Subsec. (a)(38). Pub. L. 95-142, §§3(c)(1)(D), 7(b)(2), 19(b)(2)(A), added par. (38) and made and struck out minor changes in phraseology necessitating no changes in text.

Subsec. (a)(39). Pub. L. 95-142, §§7(b)(3), 19(b)(2)(B), added par. (39).

Subsec. (a)(40). Pub. L. 95-142, §19(b)(2)(C), added par. (40).

Subsec. (a), foll. par. (40). Pub. L. 95-142, §2(b)(1)(D), added paragraph relating to waiver of requirement of cl. (A) of par. (37).

Subsec. (g). Pub. L. 95-142, §7(c), added subsec. (g).

1976—Subsec. (g). Pub. L. 94-562 struck out provisions for consent to suit and waiver of immunity by State.

1975—Subsec. (a). Pub. L. 94-48, §1, added undesignated paragraph at end of subsec. (a) relating to eligibility under this subchapter of any individual who was eligible for the month of August 1972, under a State plan approved under subchapters I, X, XIV, XVI, or part A of subchapter IV of this chapter if such individual would have been eligible for such month had the increase in monthly insurance benefits under subchapter

II of this chapter resulting from enactment of Pub. L. 92-336 not been applicable to such individual.

Subsec. (a)(23). Pub. L. 94-48, §2, inserted "except in the case of Puerto Rico, the Virgin Islands, and Guam,".

Subsec. (g). Pub. L. 94-182 added subsec. (g).

1974—Subsec. (a)(14)(B)(i). Pub. L. 93-368 substituted "may" for "shall".

1973—Subsec. (a)(5). Pub. L. 93-233, §13(a)(2)(A), (B), substituted "to administer or to supervise the administration of the plan" for "to administer the plan" and "to supervise the administration of the plan" in that order and inserted after the parenthetical phrase the conditional provision "if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI of this chapter or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter".

Subsec. (a)(10). Pub. L. 93-233, §13(a)(3), incorporated existing text in provisions designated as cl. (A), providing therein for medical assistance to individuals with respect to whom supplemental security income benefits are paid; incorporated existing par. (A) in provisions designated as cl. (B); incorporated existing par. (B) in provisions designated as cl. (C), providing therein for individuals not meeting income and resources requirements of the supplemental security income program; substituted in cls. (B)(ii), (C), (C)(i)(II) and "medical assistance" for "medical or remedial care and services" appearing in predecessor provisions and in cl. (C)(1) "except for income and resources" for "if needy" appearing in predecessor provision; and in the exception provisions included reference to par. (16) of section 1396(a) of this title in item (I), substituted "deductibles" for "the deductibles" in item (II), and added item (III).

Subsec. (a)(13)(B). Pub. L. 93-233, §13(a)(4), substituted "any plan of the State approved" for "the State's plan approved" and inserted after "part A of subchapter IV of this chapter" text reading ", or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter".

Subsec. (a)(13)(C)(ii)(I). Pub. L. 93-233, §18(x)(1), substituted reference to cl. "16" for "14".

Subsec. (a)(14)(A). Pub. L. 93-233, §13(a)(5), substituted "any plan of the State approved" for "a State plan approved" and "with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)" for "who meet the income and resources requirements of the one of such State plans which is appropriate".

Subsec. (a)(14)(B). Pub. L. 93-233, §13(a)(6)(A)-(D), inserted after "with respect to individuals" the parenthetical provision "(other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A))"; inserted after "any such State plan" the clause "and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter"; substituted "the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be," for "the one of such State plans which is appropriate"; and struck out "or who, after December 31, 1973, are included under the State plan for medical assistance pursuant to subsection (a)(10)(B) of this section approved under this subchapter" preceding the hyphen and cl. (i), respectively.

Subsec. (a)(17). Pub. L. 93-233, §13(a)(7)(A)-(D), (8), substituted: "any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter" for "the State's plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter"; "except for income and resources" for "if he met the requirements as to need"; "any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter" for "a State plan approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter"; "such aid, assistance, or benefits" for "and amount of such aid or assistance under such plan"; and "(with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program)" for "is blind or permanently and totally disabled".

Subsec. (a)(18). Pub. L. 93-233, §13(a)(6), substituted "(with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program)" for "is blind or permanently and totally disabled".

Subsec. (a)(20)(C). Pub. L. 93-233, §13(a)(9), inserted reference to section 603(a)(1)(A)(i) and (ii) of this title.

Subsec. (a)(21), (24). Pub. L. 93-233, §18(x)(4), provided for substitution of "nursing facilities" for "nursing homes".

Subsec. (a)(26)(B). Pub. L. 93-233, §18(x)(4), provided for substitution of "nursing facility" and "nursing facilities" for "nursing home" and "nursing homes", changes already executed under 1972 Amendment by Pub. L. 92-603, §278(a)(19).

Subsec. (a)(33)(A). Pub. L. 93-233, §18(x)(2), substituted "penultimate sentence" for "last sentence".

Subsec. (a)(34). Pub. L. 93-233, §18(o), inserted "(or application was made on his behalf in the case of a deceased individual)" after "he made application".

Subsec. (a)(35)(A). Pub. L. 93-233, §18(p), required the intermediate care facility to supply full and complete information respecting the person who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the intermediate care facility or any of the property or assets of the intermediate care facility.

Subsec. (a)(35) to (37). Pub. L. 93-233, §18(x)(3)(A), (B), substituted "; and" for "." at end of par. (35); and corrected numerical sequence of paragraphs, redesignating par. (37) as (36), the original subsec. (a) having been enacted without a par. (36).

Subsec. (e). Pub. L. 93-233, §18(q), substituted "each family which was receiving aid pursuant to a plan of the State approved under part A" for "each family which was eligible for assistance pursuant to part A", "for such aid because of increased hours of, or increased income from, employment" for "for such assistance because of increased income from employment", and "remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations" for

"remain eligible for such assistance for 4 calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of the income and resources limitations".

Subsec. (f). Pub. L. 93-233, §13(a)(10)(A)-(D), substituted; "no State not eligible to participate in the State plan program established under subchapter XVI of this chapter" for "no State" and "any supplemental security income payment and State supplementary payment made with respect to such individual" for "such individual's payment under subchapter XVI of this chapter" and "as recognized under State law" for "as defined in section 213 of Title 26" in parenthetical text; and inserted two end sentences for consideration of certain individuals as eligible for medical assistance under cl. (10)(A) or (C) of subsec. (a) of this section or as eligible for such assistance under cl. (10)(A) in States not providing such assistance under cl. (10)(C), respectively.

1972—Subsec. (a). Pub. L. 92-603, §§268(a), 278(b)(14), inserted provisions exempting Christian Science sanatoriums from certain nursing facility and nursing home requirements.

Subsec. (a)(9). Pub. L. 92-603, §239(a), inserted provisions to utilize State health agency for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services.

Subsec. (a)(13)(A)(ii), (C). Pub. L. 92-603, §278(a)(16), (b)(14), substituted "skilled nursing facility" for "skilled nursing home".

Subsec. (a)(13)(D). Pub. L. 92-603, §§221(c)(5), 232(a), inserted provisions that the reasonable cost of inpatient hospital services shall not exceed the amount determined under section 1395x(v) of this title and inserted reference to the consistency of methods and standards with section 1320a-1 of this title for determining the reasonable cost of inpatient hospital services.

Subsec. (a)(13)(E). Pub. L. 92-603, §249(a), added subpar. (E).

Subsec. (a)(14). Pub. L. 92-603, §208(a), substituted a nominal amount for an amount reasonably related to the recipient's income as the amount of the deduction, cost sharing, or similar charge imposed under the plan and inserted provisions covering individuals who are not receiving aid or assistance under any state plan and who do not meet the income and resources requirements and covering individuals who are included under the state plan for medical assistance pursuant to subsec. (a)(10)(B) of this section approved under this subchapter.

Subsec. (a)(23). Pub. L. 92-603, §240, inserted provisions allowing States to adopt comprehensive health care programs while still complying with medicaid requirements.

Subsec. (a)(26). Pub. L. 92-603, §§274(a), 278(a)(19), (b)(14), substituted "evaluation)" for "evaluation" and "care" for "care)" and substituted "skilled nursing facility" and "skilled nursing facilities" for "skilled nursing home" and "skilled nursing homes".

Subsec. (a)(28). Pub. L. 92-603, §§246(a), 278(a)(20), substituted "skilled nursing facility" for "skilled nursing home" and substituted a simple reference to the requirements contained in section 1395x(j) of this title with a specified exception for provisions spelling out in detail the requirements for skilled nursing homes receiving payments.

Subsec. (a)(30). Pub. L. 92-603, §237(a)(2), substituted "under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title)" for "under the plan".

Subsec. (a)(31)(A). Pub. L. 92-603, §298, struck out "which provides more than a minimum level of health care services" after "intermediate care facility".

Subsec. (a)(32). Pub. L. 92-603, §236(b)(3), added par. (32).

Subsec. (a)(33). Pub. L. 92-603, §239(b)(3), added par. (33).

Subsec. (a)(34). Pub. L. 92-603, §255(a)(3), added par. (34).

Subsec. (a)(35). Pub. L. 92-603, §299A(3), added par. (35).

Subsec. (a)(37). Pub. L. 92-603, §299D(b)(3), added par. (37).

Subsec. (d). Pub. L. 92-603, §231, repealed subsec. (d) which related to modification of state plans for medical assistance under certain circumstances.

Subsec. (e). Pub. L. 92-603, §209(a), added subsec. (e).

Subsec. (f). Pub. L. 92-603, §209(b)(1), added subsec. (f).

1971—Subsec. (a)(31). Pub. L. 92-223 added par. (31).

1969—Subsec. (c). Pub. L. 91-56, §2(c), substituted "aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs)" for "aid or assistance (other than so much of the aid or assistance as is provided for under the plan of the State approved under this subchapter)".

Subsec. (d). Pub. L. 91-56, §2(d), added subsec. (d).

1968—Subsec. (a)(2). Pub. L. 90-248, §231, changed the date on which State plans must meet certain financial participation requirements by substituting "July 1, 1969" for "July 1, 1970".

Subsec. (a)(4). Pub. L. 90-248, §210(a)(6), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (a)(10). Pub. L. 90-248, §§223(a), 241(f)(1), struck out "IV," after "I," and inserted ", and part A of subchapter IV of this chapter" after "XVI of this chapter", and designated existing provisions as item I and added item II.

Subsec. (a)(11). Pub. L. 90-248, §302(b), designated existing provisions as cl. (A) and added cl. (B).

Subsec. (a)(13). Pub. L. 90-248, §224(a), designated existing provisions as subpar. (A), incorporated existing cl. (A) in provisions designated as subpars. (B) and (C)(i), making subpar. (B) and (C) applicable to individuals receiving aid or assistance under an approved State plan and to individuals not covered under subpar. (B), respectively, added cl. (ii) of subpar. (C); redesignated former cl. (B) as subpar. (D), and deleted effective date of July 1, 1967, for former cls. (A) and (B).

Subsec. (a)(13)(A). Pub. L. 90-248, §224(c)(1), designated existing provisions as cl. (i) and added cl. (ii).

Subsec. (a)(14)(A). Pub. L. 90-248, §235(a)(1), inserted "in the case of individuals receiving aid or assistance under State plans approved under subchapters I, X, XIV, XVI, and part A of subchapter IV of this chapter,".

Subsec. (a)(14)(B). Pub. L. 90-248, §235(a)(2), inserted "inpatient hospital services or" after "respect to" and substituted "to an individual" for "him".

Subsec. (a)(15). Pub. L. 90-248, §235(a)(3), struck out subpar. (B) provision for meeting the full cost of any deductible imposed with respect to any such individual under the insurance program established by part A of such subchapter, deleted subpar. (C) designation preceding "where, under the plan", and substituted therein "established by such subchapter" for "established by part B of such subchapter".

Subsec. (a)(17). Pub. L. 90-248, §238, inserted in parenthetical expression "and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under the State's plan approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, based on the variations between shelter costs in urban areas and in rural areas" after "all groups".

Pub. L. 90-248, §241(f)(2), in cl. (B) struck out "IV," after "I," and inserted ", or part A of subchapter IV of this chapter" after "XVI of this chapter".

Subsec. (a)(23) to (30). Pub. L. 90-248, §§227(a), 228(a), 229(a), 234(a), 235(a), 237, added pars. (23), (24), (25), (26) to (28), (29), (30), respectively.

Subsec. (b)(3). Pub. L. 90-248, §241(f)(3), inserted "part A of" before "subchapter IV".

Subsec. (c). Pub. L. 90-248, §241(f)(4), struck out "IV," after "I," and inserted ", or part A of subchapter IV of this chapter" after "XVI of this chapter".

EFFECTIVE AND TERMINATION DATES OF 2010 AMENDMENT

Pub. L. 111–296, title I, §103(o)(2), Dec. 13, 2010, 124 Stat. 3192, provided that:

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section] shall take effect on the date of enactment of this Act [Dec. 13, 2010].

"(B) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section [amending this section, section 1756 of this title, and section 1232g of Title 20, Education], the State plan shall not be regarded as failing to comply with the requirements of the amendments made by this section solely on the basis of its failure to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Dec. 13, 2010]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature."

Amendment by Pub. L. 111–255 effective on the earlier of the effective date of final regulations promulgated by the Commissioner of Social Security to carry out such amendment or 180 days after Oct. 5, 2010, see section 3(d) of Pub. L. 111–255, set out as a note under section 1382a of this title.

Amendment by Pub. L. 111–255 repealed 5 years after Oct. 5, 2010, see section 3(e) of Pub. L. 111–255, set out as a note under section 1382a of this title.

Pub. L. 111–148, title II, §2002(c), Mar. 23, 2010, 124 Stat. 282, provided that: "The amendments made by subsections (a) and (b) [amending this section] take effect on January 1, 2014."

Pub. L. 111–148, title II, §2004(d), title X, §10201(a)(3), Mar. 23, 2010, 124 Stat. 283, 918, provided that: "The amendments made by this section [amending this section and sections 1396b, 1396r–1, and 1396u–7 of this title] take effect on January 1, 2014."

Pub. L. 111–148, title II, §2202(c), Mar. 23, 2010, 124 Stat. 292, provided that: "The amendments made by this section [amending this section and section 1396b of this title] take effect on January 1, 2014, and apply to services furnished on or after that date."

Pub. L. 111–148, title II, §2301(c), Mar. 23, 2010, 124 Stat. 293, provided that:

"(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396d of this title] shall take effect on the date of the enactment of this Act [Mar. 23, 2010] and shall apply to services furnished on or after such date.

"(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Mar. 23, 2010]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Pub. L. 111–148, title II, §2303(d), Mar. 23, 2010, 124 Stat. 296, provided that: "The amendments made by this section [enacting section 1396r–1c of this title and amending this section and sections 1396b, 1396d, and 1396u–7 of this title] take effect on the date of the enactment of this Act [Mar. 23, 2010] and shall apply to items and services furnished on or after such date."

Pub. L. 111–148, title II, §2402(g), Mar. 23, 2010, 124 Stat. 304, provided that: "The amendments made by subsections (b) through (f) [amending this section and sections 1396b, 1396d and 1396r of this title] take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act [Mar. 23, 2010]."

Pub. L. 111–148, title VI, §6508, Mar. 23, 2010, 124 Stat. 778, provided that:

"(a) IN GENERAL.—Except as otherwise provided in this subtitle [subtitle F (§§6501–6508) of title VI of Pub. L. 111–148, amending this section and section 1396b of this title], this subtitle and the amendments made by this subtitle take effect on January 1, 2011, without regard to whether final regulations to carry out such amendments and subtitle have been promulgated by that date.

"(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or a child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this subtitle, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Mar. 23, 2010]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Amendment by section 8002(a)(2), (b) of Pub. L. 111–148 effective Jan. 1, 2011, see section 8002(c) of Pub. L. 111–148, set out as an Effective Date note under section 300*ll* of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Pub. L. 111–5, div. B, title V, §5004(a)(2), Feb. 17, 2009, 123 Stat. 504, provided that: "The amendments made by this subsection [amending this section and section 1396r–6 of this title] shall take effect on July 1, 2009."

Pub. L. 111–5, div. B, title V, §5006(f), Feb. 17, 2009, 123 Stat. 511, provided that: "The amendments made by this section [amending this section and sections 1396o, 1396o–1, 1396p, 1396u–2, and 1397gg of this title] shall take effect on July 1, 2009."

Amendment by section 113(b)(1) of Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of this title.

Pub. L. 111–3, title II, §203(f), Feb. 4, 2009, 123 Stat. 49, provided that: "The amendments made by this section [enacting section 1396w–2 of this title and amending this section and section 1397gg of this title] are effective on the date of the enactment of this Act [Feb. 4, 2009]."

Pub. L. 111–3, title II, §211(d), Feb. 4, 2009, 123 Stat. 54, provided that:

"(1) IN GENERAL.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section [amending this section and sections 1396b and 1397ee of this title] shall take effect on January 1, 2010.

"(B) TECHNICAL AMENDMENTS.—The amendments made by—

"(i) paragraphs (1), (2), and (3) of subsection (b) [amending this section and section 1396b of this

title] shall take effect as if included in the enactment of section 6036 of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 80); and

"(ii) paragraph (4) of subsection (b) [amending section 1396b of this title] shall take effect as if included in the enactment of section 405 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2996).

"(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on October 1, 2009, was determined to be ineligible for medical assistance under a State Medicaid plan, including any waiver of such plan, solely as a result of the application of subsections (l)(22) and (x) of section 1903 of the Social Security Act (42 U.S.C. 1396b(l)(22), (x)] (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by subsection (b), had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

"(3) SPECIAL TRANSITION RULE FOR INDIANS.—During the period that begins on July 1, 2006, and ends on the effective date of final regulations issued under subclause (II) of section 1903(x)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)(v)) (as added by subsection (b)(1)(B)), an individual who is a member of a federally-recognized Indian tribe described in subclause (II) of that section who presents a document described in subclause (I) of such section that is issued by such Indian tribe, shall be deemed to have presented satisfactory evidence of citizenship or nationality for purposes of satisfying the requirement of subsection (x) of section 1903 of such Act."

[For definition of "Medicaid", see section 1(c)(2) of Pub. L. 111–3, set out as a Definitions note under section 1396 of this title.]

Pub. L. 111–3, title V, § 501(d)(3), Feb. 4, 2009, 123 Stat. 87, provided that: "The amendments made by this subsection [amending this section and section 1397gg of this title] shall take effect on January 1, 2009."

Pub. L. 111–3, title V, § 501(e)(3), Feb. 4, 2009, 123 Stat. 88, provided that: "The amendments made by this subsection [amending this section and section 1397hh of this title] shall be effective for annual reports submitted for years beginning after date of enactment [Feb. 4, 2009]."

EFFECTIVE DATE OF 2007 AMENDMENT

Pub. L. 110–90, § 8(c), Sept. 29, 2007, 121 Stat. 985, provided that: "The amendments made by this section [amending this section and section 1396u–3 of this title] shall be effective as of September 30, 2007."

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–432, div. B, title IV, § 405(c)(2)(A), Dec. 20, 2006, 120 Stat. 2999, provided that the amendment made by section 405(c)(2)(A) is effective as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171).

Pub. L. 109–171, title VI, § 6032(b), Feb. 8, 2006, 120 Stat. 74, as amended by Pub. L. 109–432, div. B, title IV, § 405(c)(2)(A)(iii), Dec. 20, 2006, 120 Stat. 3000, provided that: "Except as provided in section 6034(e) (set out below), the amendments made by subsection (a) [amending this section] take effect on January 1, 2007."

Pub. L. 109–171, title VI, § 6034(e), Feb. 8, 2006, 120 Stat. 78, provided that: "Except as otherwise provided in this chapter [chapter 3 (§§ 6031–6036) of subtitle A of title VI of Pub. L. 109–171, enacting sections 1396h and 1396u–6 of this title, amending this section and sections 1396i, 1396ddd, 1396b, and 1396v of this title, and enacting provisions set out as notes under this section and sections 1396b and 1396h of this title], in the case of a State plan under title XIX of the Social Security Act [this subchapter] which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this chapter, the State plan shall not be regarded as failing to comply with the requirements of such Act [this chapter] solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Feb. 8, 2006]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature."

Pub. L. 109–171, title VI, § 6035(c), Feb. 8, 2006, 120 Stat. 80, as amended by Pub. L. 109–432, div. B, title IV, § 405(c)(2)(A)(iii), Dec. 20, 2006, 120 Stat. 3000, provided that: "Except as provided in section 6034(e) [set out above], the amendments made by this section [amending this section] take effect on January 1, 2006."

Pub. L. 109–171, title VI, § 6062(d), Feb. 8, 2006, 120 Stat. 99, provided that: "The amendments made by this section [amending this section and sections 1396b, 1396d, and 1396o of this title] shall apply to medical assistance for items and services furnished on or after January 1, 2007."

Pub. L. 109–171, title VI, § 6085(b), Feb. 8, 2006, 120 Stat. 102, provided that: "The amendments made by subsection (a) [amending this section] shall apply to medical assistance for items and services furnished on or after the date that is 1 year after the date of enactment of this Act [Feb. 8, 2006]."

Pub. L. 109–171, title VI, § 6083(b), Feb. 8, 2006, 120 Stat. 121, provided that: "The amendments made by subsection (a) [amending this section] take effect on the date of the enactment of this Act [Feb. 8, 2006]."

EFFECTIVE DATE OF 2005 AMENDMENT

Pub. L. 109–91, title I, § 101(c), Oct. 20, 2005, 119 Stat. 2991, provided that: "The amendments made by this section [amending this section and section 1396u–3 of this title] shall be effective as of September 30, 2005."

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–265 effective July 1, 2005, see section 502(b)(4) of Pub. L. 108–265, as amended, set out as an Effective Date note under section 1754 of this title.

EFFECTIVE DATE OF 2003 AMENDMENTS

Pub. L. 108–173, title I, § 103(f)(3), Dec. 8, 2003, 117 Stat. 2160, provided that: "The amendments made by this subsection [amending this section and section 1396u–3 of this title] shall apply to calendar quarters beginning on or after April 1, 2004."

Amendment by section 236(b)(1) of Pub. L. 108–173 applicable to services furnished on or after Jan. 1, 2004, see section 236(c) of Pub. L. 108–173, set out as a note under section 1395cc of this title.

Amendment by Pub. L. 108–40 effective July 1, 2003, see section 8 of Pub. L. 108–40, set out as a note under section 603 of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–121, § 2(c), Jan. 15, 2002, 115 Stat. 2384, provided that:

"(1) EXCEPTA TECHNICAL AMENDMENT.—The amendment made by subsection (a) [amending this section] shall take effect as if included in the enactment of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106–354; 114 Stat. 1381).

"(2) BIPA TECHNICAL AMENDMENTS.—The amendments made by subsection (b) [amending this section and section 1396n of this title] shall take effect as if included in the enactment of section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–572) (as enacted into law by section 1(a)(6) of Public Law 106–554)."

EFFECTIVE DATE OF 2000 AMENDMENTS

Pub. L. 106–554, § 1(a)(6) [title VII, § 702(e)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574, provided that: "The

amendments made by this section [amending this section and sections 1396b and 1396u of this title and repealing provisions set out as a note under this section] take effect on January 1, 2001, and shall apply to services furnished on or after such date."

Pub. L. 106-354, §2(d), Oct. 24, 2000, 114 Stat. 1384, provided that: "The amendments made by this section [enacting section 1396r-1b of this title and amending this section and sections 1396b and 1396d of this title] apply to medical assistance for items and services furnished on or after October 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date."

EFFECTIVE DATE OF 1999 AMENDMENTS

Pub. L. 106-170, title II, §201(d), Dec. 17, 1999, 113 Stat. 1894, provided that: "The amendments made by this section [amending this section and sections 1396b, 1396d, and 1396o of this title and enacting provisions set out as a note below] apply to medical assistance for items and services furnished on or after October 1, 2000."

Pub. L. 106-169, title II, §121(b), Dec. 14, 1999, 113 Stat. 1830, provided that: "The amendments made by subsection (a) [amending this section and section 1396d of this title] apply to medical assistance for items and services furnished on or after October 1, 1999."

Amendment by section 205(c) of Pub. L. 106-169 effective Jan. 1, 2000, and applicable to trusts established on or after such date, see section 205(d) of Pub. L. 106-169, set out as a note under section 1382a of this title.

Amendment by section 206(b) of Pub. L. 106-169 effective with respect to disposals made on or after Dec. 14, 1999, see section 206(c) of Pub. L. 106-169, set out as a note under section 1382b of this title.

Pub. L. 106-113, div. B, §1000(a)(6) [title VI, §603(a)(3)], Nov. 29, 1999, 113 Stat. 1536, 1501A-395, provided that: "The amendments made by this subsection [amending this section and provisions set out as a note under this section] shall take effect as if included in the enactment of section 4712 of BBA (111 Stat. 508) [the Balanced Budget Act of 1997, Pub. L. 105-33]."

Pub. L. 106-113, div. B, §1000(a)(6) [title VI, §604(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A-395, provided that:

"(1) The amendment made by subsection (a)(1) [amending this section] applies to expenditures made on and after the date of the enactment of this Act [Nov. 29, 1999].

"(2) The amendments made by subsections (a)(2) and (b) [amending this section and section 1396b of this title] apply as of such date as the Secretary of Health and Human Services certifies to Congress that the Secretary is fully implementing section 1932(c)(2) of the Social Security Act (42 U.S.C. 1396u-2(c)(2))."

Pub. L. 106-113, div. B, §1000(a)(6) [title VI, §603(aa)], Nov. 29, 1999, 113 Stat. 1536, 1501A-398 provided that the amendment made by section 1000(a)(6) [title VI, §603(aa)(1)] is effective as if included in the enactment of BBA [the Balanced Budget Act of 1997, Pub. L. 105-33].

Pub. L. 106-113, div. B, §1000(a)(6) [title VI, §603(bb)], Nov. 29, 1999, 113 Stat. 1536, 1501A-398, provided that: "Except as otherwise provided, the amendments made by this section [amending this section and sections 1396b, 1396d, 1396g-1, 1396i, 1396n, 1396r, 1396r-1, 1396r-1a, 1396r-4, 1396r-6, 1396r-8, 1396t, 1396u-2, and 1396u-3 of this title] shall take effect on the date of enactment of this Act [Nov. 29, 1999]."

EFFECTIVE DATE OF 1997 AMENDMENTS

Amendment by section 4106(c) of Pub. L. 105-33 applicable to bone mass measurements performed on or after July 1, 1998, see section 4106(d) of Pub. L. 105-33, set out as a note under section 1395x of this title.

Amendment by section 4454(b)(1) of Pub. L. 105-33 effective Aug. 5, 1997, and applicable to items and services furnished on or after such date, with provision that Secretary of Health and Human Services issue regulations to carry out such amendment by not later than July 1, 1998, see section 4454(d) of Pub. L. 105-33, set out as an Effective Date note under section 1396l-5 of this title.

Amendment by section 4701(b)(2)(A)(i)-(iv), (d)(1) of Pub. L. 105-33 effective Aug. 5, 1997, and applicable to contracts entered into or renewed on Oct. 1, 1997, except as otherwise provided, see section 4710(a) of Pub. L. 105-33, set out as a note under section 1396b of this title.

Amendment by section 4702(b)(2) of Pub. L. 105-33 applicable to primary care case management services furnished on or after Oct. 1, 1997, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, see section 4710(b)(1) of Pub. L. 105-33, set out as a note under section 1396b of this title.

Section 4711(d) of Pub. L. 105-33 provided that: "This section [amending this section and sections 1396d and 1396r-4 of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997] and the amendments made by subsections (a) and (c) [amending this section and sections 1396d and 1396r-4 of this title] shall apply to payment for items and services furnished on or after October 1, 1997."

Section 4712(b)(3) of Pub. L. 105-33 provided that: "The amendments made by this subsection [amending this section and section 1396b of this title] shall apply to services furnished on or after October 1, 1997."

Pub. L. 105-33, title IV, §4712(c), Aug. 5, 1997, 111 Stat. 509, as amended by Pub. L. 106-113, div. B, §1000(a)(6) [title VI, §603(a)(2)], Nov. 29, 1999, 113 Stat. 1536, 1501A-394, which provided that the amendment made by section 4712(c) was effective for services furnished on or after Oct. 1, 2004, was repealed by Pub. L. 106-554, §1(a)(6) [title VII, §702(c)(1), (e)], Dec. 21, 2000, 114 Stat. 2763, 2763A-574, effective Jan. 1, 2001, and applicable to services furnished on or after such date.

Section 4714(c) of Pub. L. 105-33 provided that: "The amendments made by this section [amending this section and sections 1395w-4, 1396cc, 1396d of this title] shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act [Aug. 5, 1997]. The amendments made by subsection (a) [amending this section and section 1396d of this title] shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(a) and 1903(p) of the Social Security Act [subsec. (a) of this section and section 1396d(p) of this title] and that is pending as of, or is initiated after, the date of the enactment of this Act."

Section 4715(b) of Pub. L. 105-33 provided that: "The amendments made by this section [amending this section] shall apply on and after October 1, 1997."

Section 4724(c)(2) of Pub. L. 105-33 provided that: "The amendments made by paragraph (1) [amending this section] shall take effect on January 1, 1998."

Section 4724(g)(2) of Pub. L. 105-33 provided that: "The amendments made by paragraph (1) [amending this section] shall apply to suppliers of medical assistance consisting of durable medical equipment furnished on or after January 1, 1998."

Section 4731(c) of Pub. L. 105-33 provided that: "The amendments made by this section [amending this section] shall apply to medical assistance for items and services furnished on or after October 1, 1997."

Section 4741(c) of Pub. L. 105-33 provided that: "The amendments made by this section [amending this section and section 1396e of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997]."

Section 4751(c) of Pub. L. 105-33 provided that: "The amendments made by this section [amending this section] take effect on the date of the enactment of this Act [Aug. 5, 1997]."

Section 4762(b) of Pub. L. 105–33 provided that: "The amendment made by subsection (a) [amending this section] takes effect on the date of the enactment of this Act [Aug. 5, 1997]."

Section 4753(c) of Pub. L. 105–33 provided that: "Except as otherwise specifically provided, the amendments made by this section [amending this section and section 1396b of this title] shall take effect on January 1, 1998."

Section 4911(c) of Pub. L. 105–33 provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall apply to medical assistance for items and services furnished on or after October 1, 1997."

Section 4912(c) of Pub. L. 105–33 provided that: "The amendments made by this section [enacting section 1396r–1a and amending this section and section 1396b of this title] shall take effect on the date of the enactment of this Act [Aug. 5, 1997]."

Section 4913(b) of Pub. L. 105–33 provided that: "The amendment made by subsection (a) [amending this section] applies to medical assistance furnished on or after July 1, 1997."

Amendment by Pub. L. 105–12 effective Apr. 30, 1997, and applicable to Federal payments made pursuant to obligations incurred after Apr. 30, 1997, for items and services provided on or after such date, subject to also being applicable with respect to contracts entered into, renewed, or extended after Apr. 30, 1997, as well as contracts entered into before Apr. 30, 1997, to the extent permitted under such contracts, see section 11 of Pub. L. 105–12, set out as an Effective Date note under section 14401 of this title.

EFFECTIVE DATE OF 1996 AMENDMENTS

Section 1(a)(2) of Pub. L. 104–248 provided that: "The amendment made by paragraph (1) [amending this section] shall be effective as if included in the enactment of the amendments made by section 4752(c)(1) of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101–508]."[5]

Amendment by sections 108(k) and 114(b)–(d)(1), of Pub. L. 104–193 effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as an Effective Date note under section 601 of this title.

Section 913 of Pub. L. 104–193 provided that the amendment made by that section is effective Jan. 1, 1997.

EFFECTIVE DATE OF 1994 AMENDMENTS

Amendment by Pub. L. 103–448 effective Oct. 1, 1994, see section 401 of Pub. L. 103–448, set out as a note under section 1755 of this title.

Amendment by Pub. L. 103–296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103–296, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by section 13581(b)(2) of Pub. L. 103–66 effective Jan. 1, 1994, see section 13581(d) of Pub. L. 103–66, set out as a note under section 1395y of this title.

Section 13601(c) of Pub. L. 103–66 provided that: "The amendments made by subsections (a) and (b) [amending this section and section 1396d of this title] shall take effect as if included in the enactment of section 4721(a) of OBRA–1990 [Pub. L. 101–508]."

Amendment by section 13602(c) of Pub. L. 103–66 applicable to calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not regulations to carry out the amendments by section 13602(a)(1) and (c) of Pub. L. 103–66 have been promulgated by such date, see section 13602(d)(2) of Pub. L. 103–66, set out as a note under section 1396r–8 of this title.

Section 13603(f) of Pub. L. 103–66 provided that: "The amendments made by this section [amending this section and sections 1396d and 1396n of this title] shall apply to medical assistance furnished on or after January 1, 1994, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Amendment by section 13611(d)(1) of Pub. L. 103–66 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Oct. 1, 1993, without regard to whether or not final regulations to carry out the amendments by section 13611 of Pub. L. 103–66 have been promulgated by such date, see section 13611(e) of Pub. L. 103–66, set out as a note under section 1396p of this title.

Section 13622(d) of Pub. L. 103–66 provided that:

"(1) Except as provided in paragraph (2), the amendments made by subsections (a)(1), (b), and (c) [amending this section] shall apply to calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsections (a) and (b) [amending this section and section 1396b of this title], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(3) The amendment made by subsection (a)(2) [amending section 1396b of this title] shall apply to items and services furnished on or after October 1, 1993."[6]

Amendment by section 13623(a) of Pub. L. 103–66 applicable, except as otherwise provided, to calendar quarters beginning on or after Apr. 1, 1994, without regard to whether or not final regulations to carry out the amendments by section 13623 of Pub. L. 103–66 have been promulgated by such date, see section 13623(c) of Pub. L. 103–66, set out as an Effective Date note under section 1396g–1 of this title.

Section 13625(b) of Pub. L. 103–66 provided that: "Section 1902(a)(61) of the Social Security Act [subsec. (a)(61) of this section] (as added by subsection (a)) shall take effect January 1, 1995, and the standards referred to in such section shall be established not later than March 31, 1994."

Section 13631(e)(2) of Pub. L. 103–66 provided that: "The amendments made by paragraph (1) [amending this section] shall take effect on the date of the enactment of this Act [Aug. 10, 1993]."

Section 13631(f)(3) of Pub. L. 103–66 provided that:

"(A) Except as provided in subparagraph (B), the amendments made by this subsection [amending this section and section 1396d of this title] shall apply to calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act (this subchapter] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its fail-

ure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 10, 1993]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Section 13631(l) of Pub. L. 103–66 provided that: "Except as otherwise provided in this section, the amendments made by this section [enacting section 1396s of this title, transferring former section 1396s of this title to section 1396v of this title, and amending this section and sections 1396b and 1396d of this title] shall apply to payments under State plans approved under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after October 1, 1994."

EFFECTIVE DATE OF 1991 AMENDMENT

Section 2(c)(1) of Pub. L. 102–234 provided that: "The amendments made by this section [amending this section and section 1396b of this title] shall take effect January 1, 1992, without regard to whether or not regulations have been promulgated to carry out such amendments by such date."

Section 3(c)(1) of Pub. L. 102–234 provided that: "The amendments made by this section [amending this section and sections 1396b and 1396r-4 of this title] shall take effect January 1, 1992."

EFFECTIVE DATE OF 1990 AMENDMENT

Section 4402(a) of Pub. L. 101–508 provided that:

"(1) The amendments made by this section [enacting section 1396e of this title and amending this section and sections 1396b and 1396d of this title] apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a) [enacting section 1396e of this title and amending this section], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Nov. 5, 1990]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Section 4501(f) of Pub. L. 101–508 provided that: "The amendments made by this section [amending this section and sections 1395v and 1396d of this title] shall apply to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendments are promulgated by such date; except that the amendments made by subsection (e) [amending this section and section 1396d of this title] shall apply to determinations of income for months beginning with January 1991."

Section 4601(b) of Pub. L. 101–508 provided that:

"(1) The amendments made by this subsection [probably should be "section", which amended this section and sections 1396b, 1396d, and 1396r-6 of this title] apply (except as otherwise provided in this subsection) to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection [section], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Nov. 5, 1990]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Section 4602(b) of Pub. L. 101–508 provided that: "The amendments made by subsection (a) [amending this section] apply to payments under title XIX of the Social Security Act [this subchapter] for calenar [sic] quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Section 4603(b) of Pub. L. 101–508 provided that:

"(1) INFANTS.—The amendment made by subsection (a)(1) [amending this section] shall apply to individuals born on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

"(2) PREGNANT WOMEN.—The amendments made by subsection (a)(2) [amending this section] shall apply with respect to determinations to terminate the eligibility of women, based on change of income, made on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Section 4604(d) of Pub. L. 101–508 provided that:

"(1) The amendments made by this subsection [probably should be "section", which amended this section and section 1396n of this title] shall become effective with respect to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection [section], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Nov. 5, 1990]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Amendment by section 4701(b)(1) of Pub. L. 101–508 effective Jan. 1, 1991, see section 4701(c) of Pub. L. 101–508, set out as a note under section 1396b of this title.

Section 4704(f) of Pub. L. 101–508 provided that: "The amendments made by this section [amending this section and sections 1395b, 1396d, and 1396n of this title] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989 [Pub. L. 101–239]."

Section 4708(b) of Pub. L. 101–508 provided that: "The amendments made by this section [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Nov. 5, 1990]."

Section 4711(e) of Pub. L. 101–508 provided that:

"(1) Except as provided in this subsection, the amendments made by this section [enacting section 1396t of this title and amending this section and sections 1396b and 1396d of this title] shall apply to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2)(A) The amendments made by subsection (c)(1) [amending this section] shall apply to home and community care furnished on or after July 1, 1991, or, if later, 30 days after the date of publication of interim regulations under section 1920(k)(1) [section 1396t(k)(1) of this title].

"(B) The amendment made by subsection (c)(2) [amending section 1396b of this title] shall apply to civil money penalties imposed after the date of the enactment of this Act [Nov. 5, 1990]."

Section 4713(c) of Pub. L. 101-508 provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall apply to medical assistance furnished on or after January 1, 1991."

Section 4715(b) of Pub. L. 101-508 provided that: "The amendment made by subsection (a) [amending this section] shall apply to treatment of income for months beginning more than 30 days after the date of the enactment of this Act [Nov. 5, 1990]."

Section 4732(a) of Pub. L. 101-508 provided that: "The amendments made by this section [amending this section and section 1396b of this title] shall take effect on the date of the enactment of this Act [Nov. 5, 1990]."

Section 4751(c) of Pub. L. 101-508 provided that: "The amendments made by this section [amending this section and sections 1396b and 1396r of this title] shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act [Nov. 5, 1990]."

Section 4752(c)(2) of Pub. L. 101-508 provided that: "The amendments made by paragraph (1) [amending this section] shall apply to medical assistance for calendar quarters beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x) of the Social Security Act [subsec. (x) of this section]."

Section 4754(b) of Pub. L. 101-508 provided that: "The amendment made by subsection (a) [amending this section] shall apply to sanctions effected more than 60 days after the date of the enactment of this Act [Nov. 5, 1990]."

Section 4755(c)(1) of Pub. L. 101-508 provided that the amendment made by that section is effective July 1, 1990.

Section 4801(e)(11) of Pub. L. 101-508 provided that the amendment made by that section is effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1396r(f)(4) of this title.

Section 4801(e)(19) of Pub. L. 101-508 provided that: "Except as provided in paragraphs (7), (11), and (16), the amendments made by this subsection [amending this section and sections 1396b and 1396r of this title, repealing section 1396g of this title, and amending provisions set out as a note under this section] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203]."

EFFECTIVE DATE OF 1989 AMENDMENTS

Amendment by section 6115(c) of Pub. L. 101-239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101-239, set out as a note under section 1395x of this title.

Section 6401(c) of Pub. L. 101-239 provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396b of this title] shall apply to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after April 1, 1990, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Dec. 19, 1989]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Section 6402(c), formerly § 6402(d), of Pub. L. 101-239, as renumbered and amended by Pub. L. 101-508, title IV, § 4704(e)(2), Nov. 5, 1990, 104 Stat. 1388-172, provided that: "The amendments made by this section [enacting section 1396r-7 of this title and amending this section] (except as otherwise provided in such amendments) shall take effect on the date of the enactment of this Act [Dec. 19, 1989]."

Section 6403(c) of Pub. L. 101-239 provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall take effect on April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Section 6404(d) of Pub. L. 101-239 provided that:

"(1) The amendments made by this section [amending this section and section 1396d of this title] apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Dec. 19, 1989]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Section 6405(c) of Pub. L. 101-239 provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall become effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990."

Section 6406(b) of Pub. L. 101-239 provided that: "The amendments made by subsection (a) [amending this section] shall take effect on July 1, 1990, without regard to whether regulations to carry out such amendments have been promulgated by such date."

Section 6408(c)(2) of Pub. L. 101-239 provided that: "The amendments made by paragraph (1) [amending this section] shall apply to services furnished on or after April 1, 1990, without regard to whether or not final regulations have been promulgated by such date to implement such amendments."

Section 6408(d)(5) of Pub. L. 101-239 provided that:

"(A) The amendments made by this subsection [amending this section and sections 1396d and 1396o of this title] apply (except as provided under subpara-

graph (B)) to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after July 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Dec. 19, 1989]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Section 6411(a)(2) of Pub. L. 101–239 provided that: "The amendment made by paragraph (1) [amending this section] shall apply as if it had been included in the enactment of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360]."

Amendment by section 6411(d)(3)(B) of Pub. L. 101–239 applicable to employment and contracts as of 90 days after Dec. 19, 1989, see section 6411(d)(4)(B) of Pub. L. 101–239, set out as a note under section 1395mm of this title.

Section 6411(e)(4) of Pub. L. 101–239 provided that:

"(A) SPOUSAL TRANSFERS.—The amendments made by paragraph (1) [amending section 1396p of this title] shall apply to transfers occurring after the date of the enactment of this Act [Dec. 19, 1989].

"(B) OTHER AMENDMENTS.—Except as provided in subparagraph (A), the amendments made by this subsection [amending this section and sections 1396p and 1396r–5 of this title] shall apply as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360]."

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Section 8434(c) of Pub. L. 100–647 provided that: "The amendment made by this section [amending this section and section 1396d of this title] shall be effective as if included in the enactment of section 301 of the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100–360]."

Amendment by section 202(c)(4) of Pub. L. 100–485 effective Oct. 1, 1990, with provision for earlier effective dates in case of States making certain changes in their State plans and formally notifying the Secretary of Health and Human Services of their desire to become subject to the amendments by title II of Pub. L. 100–485 at such earlier effective dates, see section 202(a), (b)(1)(A) of Pub. L. 100–485, set out as a note under section 671 of this title.

Section 303(f) of Pub. L. 100–485, as amended by Pub. L. 101–239, title VI, § 6411(i)(2), Dec. 19, 1989, 103 Stat. 2279; Pub. L. 104–193, title I, § 110(q), Aug. 22, 1996, 110 Stat. 2176, provided that:

"(1) The amendments made by this section [enacting section 1396r–6 of this title, amending this section and section 1396d of this title] (other than subsections (b)(3), (d), and (e) [amending this section and section 602 of this title and provisions formerly set out as a note under section 606 of this title]) shall apply to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after April 1, 1990 (or, in the case of the Commonwealth of Kentucky, October 1, 1990) (without regard to whether regulations to implement such amendments are promulgated by such date), with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act [part A of subchapter IV of this chapter] on or after such date.

"(2) The amendment made by subsection (b)(3) [amending section 602 of this title] shall become effective on April 1, 1990, but such amendment shall not apply with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act before such date.

"(3) The amendment made by subsection (d) [amending this section] shall become effective on the effective date of section 402(a)(43) of the Social Security Act, as inserted by section 403(a) of this Act [the first day of the first calendar quarter to begin one year or more after Oct. 13, 1988, see section 403(b) of Pub. L. 100–485, 102 Stat. 2398].

"(4) The amendment made by subsection (e) [amending provisions formerly set out as a note under section 606 of this title] shall take effect on October 1, 1988."

Section 401(g) of Pub. L. 100–485, as amended by Pub. L. 103–432, title II, § 234(a), Oct. 31, 1994, 108 Stat. 4466, provided that:

"(1) Except as provided in paragraph (2), and in section 1905(m)(2) of the Social Security Act [section 1396d(m)(2) of this title] (as added by subsection (d)(2) of this section), the amendments made by this section [amending this section and sections 602, 607, and 1396d of this title] shall become effective on October 1, 1990.

"(2) The amendments made by this section shall not become effective with respect to Puerto Rico, American Samoa, Guam, or the Virgin Islands, until the date of the repeal of the limitations contained in section 1108(a) of the Social Security Act [section 1308(a) of this title] on payments to such jurisdictions for purposes of making maintenance payments under parts A and E of title IV of such Act [parts A and E of subchapter IV of this chapter]."

[Section 234(b) of Pub. L. 103–432 provided that: "The amendment made by subsection (a) [amending section 401(g)(2) of Pub. L. 100–485, set out above] shall take effect as if included in the provision of the Family Support Act of 1988 [Pub. L. 100–485] to which the amendment relates at the time such provision became law."]

Amendment by section 608(d)(14)(I), (15)(A), (B), (15)(C), (27)(F)–(H), (28) of Pub. L. 100–486 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 204(d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Amendment by section 301(e)(2) of Pub. L. 100–360 effective July 1, 1989, see section 301(e)(3) of Pub. L. 100–360, set out as a note under section 1395v of this title.

Section 301(h) of Pub. L. 100–360, as amended by Pub. L. 100–485, title VI, § 608(d)(14)(K), Oct. 13, 1988, 102 Stat. 2416, provided that:

"(1) The amendments made by this section [amending this section and sections 1395v, 1396b, and 1396d of this title] apply (except as provided in subsections (e) and (f) [set out as notes under section 1395v and 1396b of this title] and under paragraph (2)) to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after January 1, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

"(A) monthly premiums under title XVIII of such Act [subchapter XVIII of this chapter] for months beginning with January 1989, and

"(B) items and services furnished on and after January 1, 1989.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by

the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first session of the State legislature that begins after the date of the enactment of this Act [July 1, 1988]. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Section 302(f) of Pub. L. 100-360 provided that:

"(1) IN GENERAL.—The amendments made by this section [amending this section and sections 1396b and 1396r-4 of this title] apply (except as provided in this subsection) to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after July 1, 1988, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) PAYMENT ADJUSTMENT.—The amendments made by subsection (b)(2) [amending section 1396r-4 of this title] shall take effect on the date of the enactment of this Act [July 1, 1988].

"(3) DELAY FOR STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than subsection (b)(2)), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a regular legislative session of 2 years, each year of such session shall be deemed to be a separate regular session of the State legislature."

Amendment by section 303(d) of Pub. L. 100-360 effective on and after Apr. 8, 1988, with additional provision for superseding of certain administrative regulations, see section 303(g)(4) of Pub. L. 100-360, set out as an Effective Date note under section 1396r-5 of this title.

Amendment by section 303(a)(1), (5) of Pub. L. 100-360 applicable to medical assistance furnished on or after Oct. 1, 1988, see section 303(g)(6) of Pub. L. 100-360, set out as an Effective Date note under section 1396r-5 of this title.

Subsec. (a)(51)(A), as enacted by section 303(e)(2)-(4) of Pub. L. 100-360, applicable to payments under this subchapter for calendar quarters beginning on or after Sept. 30, 1989, without regard to whether or not final regulations to carry out that paragraph have been promulgated by that date, see section 303(g)(1)(A) of Pub. L. 100-360, set out as an Effective Date note under section 1396r-5 of this title.

Subsec. (a)(51)(B), as enacted by section 303(e)(2)-(4) of Pub. L. 100-360, applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1988 (except in certain situations requiring State legislative action), without regard to whether or not final regulations to carry out that paragraph have been promulgated by that date, with an exception for resources disposed of before July 1, 1988, see section 303(g)(2)(A), (C), (5) of Pub. L. 100-360, set out as an Effective Date note under section 1396r-5 of this title.

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by section 411(k)(5), (7)(B)-(D), (10)(C)(ii), (iv), (17)(B), (I)(3)(E), (H), (J), (6)(C), (D), (8)(C), and (n)(2), (4) of Pub. L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, effective as if included in the enactment of that provision in Pub. L. 100-203, see section 411(a) of Pub. L. 100-360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENTS

For effective date of amendment by section 4072(d) of Pub. L. 100-203, see section 4072(e) of Pub. L. 100-203, set out as a note under section 1395x of this title.

Section 4101(a)(3) of Pub. L. 100-203 provided that: "The amendments made by this subsection [amending this section] shall apply to medical assistance furnished on or after July 1, 1988."

Section 4101(b)(3) of Pub. L. 100-203 provided that: "The amendments made by this subsection [amending this section and provisions set out below] shall apply with respect to medical assistance furnished on or after July 1, 1988."

Amendment by section 4101(c)(2) of Pub. L. 100-203 applicable to medical assistance furnished on or after Oct. 1, 1988, see section 4101(c)(3) of Pub. L. 100-203, set out as a note under section 1396d of this title.

Section 4101(e)(6) of Pub. L. 100-203 provided that:

"(A) The amendment made by paragraph (1) [amending this section] shall become effective on the date of enactment of this Act [Dec. 22, 1987].

"(B) The amendments made by paragraphs (2) and (3) [amending this section] shall be effective as if they had been included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99-272].

"(C) The amendment made by paragraph (4) [amending this section] shall apply to elections made on or after the enactment of this Act.

"(D) The amendment made by paragraph (5) [amending this section] shall apply as if included in the enactment of section 9401 of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99-509]."

Section 4113(c)(3) of Pub. L. 100-203 provided that: "The amendments made by this subsection [amending this section] shall apply to services furnished on and after July 1, 1988."

Section 4118(c)(2) of Pub. L. 100-203 provided that: "The amendment made by paragraph (1) [amending this section] shall be effective as if it were included in section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 [Pub. L. 97-248]."

Section 4118(h)(3), formerly §4118(h)(2), of Pub. L. 100-203, as renumbered and amended by Pub. L. 100-360, title IV, §411(k)(10)(G)(ii), July 1, 1988, 102 Stat. 796, provided that: "The amendments made by this subsection [amending this section and section 1396b of this title] shall apply to costs incurred after the date of the enactment of this Act [Dec. 22, 1987]."

Section 4118(m)(2) of Pub. L. 100-203 provided that: "The amendments made by paragraph (1) [amending this section and repealing section 1320a-8 of this title] shall apply to audits conducted after the date of the enactment of this Act [Dec. 22, 1987]."

Amendments by sections 4211(b)(1), (h)(1)-(5), 4212(d)(2), (3), (e)(1) of Pub. L. 100-203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, and except that subsec. (a)(28)(B) of this section as amended by section 4211(b) of Pub. L. 100-203 applicable to calendar quarters beginning more than 6 months after Dec. 22, 1987, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100-203, as amended, set out as an Effective Date note under section 1396r of this title.

Section 4212(d)(4) of Pub. L. 100-203 provided that: "The amendments made by this subsection [amending this section and section 1396b of this title] shall not apply to a State until such date (not earlier than October 1, 1990) as of which the Secretary determines that—

"(A) the State has specified the resident assessment instrument under section 1919(e)(5) of the Social Security Act [section 1396r(e)(5) of this title], and

"(B) the State has begun conducting surveys under section 1919(g)(2) of such Act."

Amendment by section 4213(b)(1) of Pub. L. 100-203 applicable to payments under this subchapter for calendar quarters beginning on or after Dec. 22, 1987, without regard to whether regulations implementing such amendments are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(b) of Pub. L. 100-203, as amended, set out as an Effective Date note under section 1396r of this title.

Section 4213(b) of Pub. L. 100-203 provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to certifications or recertifications during the period beginning on July 1, 1988, and ending on October 1, 1990."

Amendment by section 9115(b) of Pub. L. 100-203 effective July 1, 1989, see section 9115(c) of Pub. L. 100-203, set out as a note under section 1382 of this title.

Section 9119(d)(2) of Pub. L. 100-203, as added by Pub. L. 100-360, title IV, § 411(n)(4), formerly § 411(n)(3), July 1, 1988, 102 Stat. 807, and renumbered by Pub. L. 100-485, title VI, § 608(d)(28), Oct. 13, 1988, 102 Stat. 2423, provided that: "The amendments made by paragraph (1) [amending this section] apply to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Amendment by sections 5(a) and 8(f) of Pub. L. 100-93, applicable, with certain exception, to payments under subchapter XIX of this chapter for calendar quarters beginning more than thirty days after Aug. 18, 1987, without regard to whether or not final regulations to carry out such amendments have been published by such date, see section 15(c) of Pub. L. 100-93, set out as a note under section 1320a-7 of this title.

Amendment by section 7 of Pub. L. 100-93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100-93, set out as a note under section 1320a-7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENTS

Section 10(b) of Pub. L. 99-643 provided that:

"(1) Except as provided in paragraph (2), the amendments made by sections 3, 4, 5, 6, and 7 [amending this section and sections 1382, 1382c, 1382h, 1383, and 1396a of this title] shall become effective on July 1, 1987.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the requirements imposed by the amendments made by section 3(b) [amending this section] and section 7 of this Act [amending this section and section 1382h of this title], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such additional requirements until 60 days after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Nov. 10, 1986]."

Section 11005(c)(2) of Pub. L. 99-570 provided that: "The amendments made by subsection (b) [amending this section] shall become effective on January 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Amendment by Pub. L. 99-514 effective, except as otherwise provided, as if included in enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272, see section 1895(c) of Pub. L. 99-514, set out as a note under section 162 of Title 26, Internal Revenue Code.

Amendment by section 9320(h)(3) of Pub. L. 99-509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99-509, as amended, set out as notes under section 1395k of this title.

Section 9401(f) of Pub. L. 99-509, as amended by Pub. L. 100-203, title IV, § 4101(b)(2)(C), Dec. 22, 1987, 101 Stat. 1330-141, provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396b of this title] shall apply to medical assistance furnished in calendar quarters beginning on or after April 1, 1987.

"(2) Subparagraph (G) of section 1902(l)(1) of the Social Security Act [subsec. (l)(1)(C) of this section], as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1987.

"(3) An amendment made by this section shall become effective as provided in paragraph (1) or (2) without regard to whether or not final regulations to carry out such amendment have been promulgated by the applicable date."

Section 9402(c) of Pub. L. 99-509 provided that: "The amendments made by this section [amending this section] shall apply to payments to States for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Section 9403(h) of Pub. L. 99-509 provided that: "The amendments made by this section [amending this section and sections 1396b, 1396d, and 1396o of this title] apply to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Section 9404(c) of Pub. L. 99-509 provided that:

"(1) The amendments made by this section [amending this section and section 1396d of this title] apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after July 1, 1987, without regard to whether regulations to implement such amendments are promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Oct. 21, 1986]."

Section 9406(c) of Pub. L. 99-509 provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396b of this title] shall apply to medical assistance furnished to aliens on or after January 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made in subsection (b) [amending this section], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Oct. 21, 1986]."

Section 9407(d) of Pub. L. 99-509 provided that: "The amendments made by this section [enacting section

1396r–1 of this title and amending this section and sections 1395b and 1396s of this title] shall apply to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Section 9408(d) of Pub. L. 99–509 provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall apply to services furnished on or after the date of the enactment of this Act [Oct. 21, 1986]."

Section 9431(c) of Pub. L. 99–509 provided that: "The amendments made by this section [amending this section and section 1396b of this title] apply to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date."

Section 9433(b) of Pub. L. 99–509 provided that: "The amendment made by subsection (a) [amending section 2173 of Pub. L. 97–35, which amended this section] shall apply as though it was included in the enactment of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35)."

Section 9435(f) of Pub. L. 99–509 provided that: "The amendments made by this section [amending this section and section 1396d of this title and provisions set out as notes under this section and sections 1396d and 1396n of this title] shall be effective as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272]."

Section 9501(d)(2), (3) of Pub. L. 99–272 provided that:

"(2) OPTIONAL SERVICES.—The amendments made by subsection (b) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].

"(3) CONTINUED COVERAGE.—The amendment made by subsection (c) [amending this section] shall apply to medical assistance furnished to a woman on or after the date of the enactment of this Act."

Section 9503(g) of Pub. L. 99–272 provided that:

"(1) Except as otherwise provided, the amendments made by this section [amending this section and sections 1396b and 1396k of this title and section 1144 of Title 29, Labor, and enacting provisions set out as notes under this section and section 1144 of Title 29] shall apply to calendar quarters beginning on or after the date of the enactment of this Act [Apr. 7, 1986].

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

"(3) No penalty may be applied against any State for a violation of section 1902(a)(25) of the Social Security Act [subsec. (a)(25) of this section] occurring prior to the effective date of the amendments made by this section.

"(4) The amendment made by subsection (c) [enacting provisions set out below] shall become effective on the date of the enactment of this Act [Apr. 7, 1986]."

Section 9505(e) of Pub. L. 99–272, as amended by Pub. L. 99–509, title IX, §9435(d)(1), Oct. 21, 1986, 100 Stat. 2070, provided that: "The amendments made by this section [amending this section and sections 1396d and 1396o of this title] shall apply to medical assistance provided for hospice care furnished on or after the date of the enactment of this Act [Apr. 7, 1986], without regard to whether or not regulations to carry out the amendments have been promulgated by that date."

Section 9506(b), (c) of Pub. L. 99–272, as amended by Pub. L. 99–509, title IX, §9435(c), Oct. 21, 1986, 100 Stat. 2070, provided that:

"(b) EFFECTIVE DATE.—The amendment made by subsection (a) [amending this section] shall apply to medical assistance furnished on or after the first day of the second month beginning after the date of the enactment of this Act [Apr. 7, 1986].

"(c) EXCEPTION.—The amendment made by subsection (a) [amending this section] shall not apply to any trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded."

Section 9509(b) of Pub. L. 99–272 provided that:

"(1) Except as provided in paragraphs (2) and (3), the amendments made by this section [amending this section and enacting provisions set out below] shall apply to medical assistance furnished on or after October 1, 1985, but only with respect to changes of ownership occurring on or after such date.

"(2) The amendments made by this section shall not apply with respect to a change of ownership pursuant to an enforceable agreement entered into prior to October 1, 1985.

"(3) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet the requirements imposed by the amendments made by this section before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Apr. 7, 1986]."

Section 9510(b) of Pub. L. 99–272, as amended by Pub. L. 99–509, title IX, §9435(d)(2), Oct. 21, 1986, 100 Stat. 2070, provided that: "The amendment made by this section [amending this section] shall apply with respect to payment for services furnished on or after October 1, 1985, without regard to whether or not regulations to carry out the amendment have been promulgated by that date."

Section 9529(a)(2) of Pub. L. 99–272 provided that: "The amendment made by paragraph (1) [amending this section] shall apply to medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of the enactment of this Act [Apr. 7, 1986]."

Section 9529(b)(3) of Pub. L. 99–272 provided that: "This subsection, and the amendments made by this subsection [amending this section and enacting provisions set out below], shall apply to adoption assistance agreements entered into before, on, or after the date of the enactment of this Act [Apr. 7, 1986]."

Amendment by section 12305(b)(3) of Pub. L. 99–272 applicable to medical assistance furnished in or after first calendar quarter beginning more than 90 days after Apr. 7, 1986, see section 12305(c) of Pub. L. 99–272, set out as a note under section 673 of this title.

EFFECTIVE DATE OF 1984 AMENDMENTS

Amendment by Pub. L. 98–617 effective as if originally included in the Deficit Reduction Act of 1984, Pub. L. 98–369, see section 3(c) of Pub. L. 98–617, set out as a note under section 1395f of this title.

Amendment by section 2303(g)(1) of Pub. L. 98–369 applicable to clinical diagnostic laboratory tests furnished on or after July 1, 1984, but not applicable to clinical diagnostic laboratory tests furnished to inpatients of a provider operating under a waiver granted pursuant to section 602(k) of Pub. L. 98–21, set out as a note under section 1395y of this title, see section 2303(j)(1) and (3) of Pub. L. 98–369, set out as a note under section 1395f of this title.

Section 2314(c)(3) of Pub. L. 98–369 provided that:

"(A) Except as provided in subparagraph (B), the amendments made by subsection (b) [amending this section] shall apply to medical assistance furnished on or after October 1, 1984.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section [amending this section and section 1395x of this title and enacting provisions set out as a note under section 1395x of this title], the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2335(e) of Pub. L. 98-369 effective July 18, 1984, see section 2335(g) of Pub. L. 98-369, set out as a note under section 1395f of this title.

Section 2361(d) of Pub. L. 98-369 provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and sections 606 and 1396d of this title] shall apply to calendar quarters beginning on or after October 1, 1984, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Section 2362(b) of Pub. L. 98-369 provided that: "The amendment made by subsection (a) [amending this section] shall apply to children born on or after October 1, 1984."

Amendment by section 2363(a)(1) of Pub. L. 98-369 applicable to calendar quarters beginning on or after July 18, 1984, except that, in the case of individuals admitted to skilled nursing facilities before that date, the amendment shall not require recertifications sooner or more frequently than were required under the law in effect before that date, see section 2363(c) of Pub. L. 98-369, set out as a note under section 1396b of this title.

Section 2367(c) of Pub. L. 98-369 provided that:

"(1) Except as provided in paragraph (2), the amendments made by this section [amending this section and section 1396k of this title] shall become effective on October 1, 1984.

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [July 18, 1984]."

Section 2368(c) of Pub. L. 98-369 provided that: "The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

Amendment by section 2651(c) of Pub. L. 98-369 effective Apr. 1, 1985, except as otherwise provided, see section 2651(f)(2) of Pub. L. 98-369, set out as an Effective Date note under section 1320b-7 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Amendment by section 131(a), (c) of Pub. L. 97-248 effective Oct. 1, 1982, see section 131(d) of Pub. L. 97-248, formerly § 131(c), redesignated Pub. L. 97-448, title III, § 309(a)(8), Jan. 12, 1983, 96 Stat. 2403, set out as an Effective Date note under section 1396c of this title.

Amendment by section 132(a), (c) of Pub. L. 97-248 effective Sept. 3, 1982, see section 132(d) of Pub. L. 97-248, set out as an Effective Date note under section 1396p of this title.

Section 134(b) of Pub. L. 97-248 provided that: "The amendment made by subsection (a) [amending this section] shall become effective on October 1, 1982."

Amendment by section 135(d) of Pub. L. 97-248 effective Oct. 1, 1982, see section 135(e) of Pub. L. 97-248, set out as a note under section 1301 of this title.

Section 137(d) of Pub. L. 97-248 provided that:

"(1) Except as otherwise provided in this section, any amendment to the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97-35] made by this section [amending this section and sections 1320a-1 and 1396b of this title and provisions set out as a note under section 603 of this title] shall be effective as if it had been originally included in the provision of the Omnibus Budget Reconciliation Act of 1981 to which such amendment relates.

"(2) Except as otherwise provided in this section, any amendment to the Social Security Act [this chapter] made by the preceding provisions of this section [amending this section and sections 701, 705, 1320a-7a, 1320b-4, 1396b, 1396d, and 1396n of this title] shall be effective as if it had been originally included as a part of that provision of the Social Security Act to which it relates, as such provision of the Social Security Act was amended by the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97-35]."

Amendment by section 149(a) of Pub. L. 97-248 effective with respect to contracts entered into or renewed on or after Sept. 3, 1982, see section 149 of Pub. L. 97-248, set out as an Effective Date note under section 1320c of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Section 2113(c) of Pub. L. 97-35 provided that: "The amendments made by this section [amending this section and sections 1320c, 1320c-1, 1320c-3, 1320c-4, 1320c-7, 1320c-8, 1320c-9, 1320c-11, 1320c-17, 1320c-21, and 1396b of this title and repealing sections 1320c-13 and 1320c-20 of this title] apply to agreements with Professional Standards Review Organizations entered into on or after October 1, 1981."

Section 2171(c) of Pub. L. 97-35 provided that: "The amendments made by this section [amending this section] shall become effective on the date of the enactment of this Act [Aug. 13, 1981]."

Section 2172(c) of Pub. L. 97-35 provided that: "The amendments made by this section [amending this section and section 1396d of this title] shall become effective on the date of the enactment of this Act [Aug. 13, 1981]."

Section 2173(b)(2) of Pub. L. 97-35 provided that: "The amendment made by paragraph (1) [amending this section] shall not apply with respect to services furnished before the date the Secretary of Health and Human Services first promulgates and has in effect final regulations (on an interim or other basis) to carry out section 1902(a)(13)(A) of the Social Security Act [subsec. (a)(13)(A) of this section] (as amended by this subtitle)."

Section 2174(c) of Pub. L. 97-35 provided that: "The amendments made by this section [amending this section and section 1396b of this title] shall apply to services furnished on or after October 1, 1981."

Section 2175(d)(2) of Pub. L. 97-35 provided that:

"(A) The amendments made by paragraph (1) [amending this section] shall (except as provided under subparagraph (B)) be effective with respect to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after October 1, 1981.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirement imposed by the amendment made by paragraph (1)(C), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 13, 1981]."

Section 2178(c) of Pub. L. 97-35 provided that: "The amendments made by this section [amending this section and section 1396b of this title] shall apply with respect to services furnished, under a State plan approved under title XIX of the Social Security Act [this subchapter], on or after October 1, 1981; except that such amendments shall not apply with respect to services furnished by a health maintenance organization under a contract with a State entered into under such title before October 1, 1981 unless the organization requests that such amendments apply and the Secretary of Health and Human Services and the single State agency (administering or supervising the administration of the State plan under such title) agree to such request."

Section 2181(b) of Pub. L. 97-35, as amended by Pub. L. 97-248, title I, § 137(a)(4), Sept. 3, 1982, 96 Stat. 376, provided that: "The amendment made by subsection (a)(1) [amending section 603 of this title] shall apply to reductions for calendar quarters beginning on or after June 30, 1974, and the amendments made by subsection (a)(2) [amending this section] shall take effect on October 1, 1981, except that, in the case of a State plan under title XIX of the Social Security Act [this subchapter] which the Secretary determines requires State legislation in order to incorporate the provisions required to be included by this section into such State plan, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to include the provisions required to be included in such State plan by subsection (a)(2) of this section before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act [Aug. 13, 1981], but the requirements previously set forth in paragraphs (1) through (3) of section 403(g) of the Social Security Act [section 603(g)(1)–(3) of this title] (prior to its repeal by this section) shall apply under title XIX of such Act to such State on and after October 1, 1981, whether or not the provisions required to be included by this section in the State plan under title XIX have been incorporated into such State plan."

For effective date, savings, and transitional provisions relating to amendment by section 2193(c)(9) of Pub. L. 97-35, see section 2194 of Pub. L. 97-35, set out as a note under section 701 of this title.

EFFECTIVE DATE OF 1980 AMENDMENT

Amendment by section 902(b) of Pub. L. 96-499 effective on date on which final regulations to implement the amendment are first issued, see section 902(c) of Pub. L. 96-499, set out as a note under section 1395x of this title.

Section 914(b)(2) of Pub. L. 96-499, as amended by Pub. L. 97-248, title I, § 137(c)(1), Sept. 3, 1982, 96 Stat. 381, provided that:

"(A) The amendments made by paragraph (1) [amending this section] shall (except as provided under subparagraph (B)) apply to cost reporting periods, beginning on or after April 1, 1981, of an entity providing services under a State plan approved under title XIX of the Social Security Act [this subchapter]."

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act."

Section 918(b)(2) of Pub. L. 96-499 provided that:

"(A) The amendments made by paragraph (1) [enacting this section] shall (except as otherwise provided in subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act [this subchapter], on and after the first day of the first calendar quarter that begins more than six months after the date of the enactment of this Act [Dec. 5, 1980].

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act."

Section 962(b) of Pub. L. 96-499 provided that: "The amendment made by subsection (a) [amending this section] shall become effective on October 1, 1980."

Section 965(c) of Pub. L. 96-499 provided that:

"(1) The amendments made by this section [amending this section and section 1396d of this title] shall (except as provided under paragraph (2)) be effective with respect to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning more than one hundred and twenty days after the date of the enactment of this Act [Dec. 5, 1980].

"(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act."

EFFECTIVE DATE OF 1978 AMENDMENT

Section 14(a)(2) of Pub. L. 95-559 provided that:

"(A) Except as provided in subparagraph (B), the amendments made by paragraph (1) [amending this section] shall take effect one hundred and eighty days after the date of the enactment of this Act [Nov. 1, 1978].

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act [this subchapter] which the Secretary determines requires State legislation in order for the plan to meet the requirement added by the amendments made by paragraph (1), such amendments shall not apply with respect to such State plan before ninety days after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act."

EFFECTIVE DATE OF 1977 AMENDMENTS

Amendment by Pub. L. 95-210 applicable to medical assistance provided, under a State plan approved under subchapter XIX of this chapter, on and after the first day of the first calendar quarter that begins more than six months after Dec. 13, 1977, with exception for plans requiring State legislation, see section 2(f) of Pub. L. 95-210, set out as a note under section 1396cc of this title.

Amendment by section 2(a)(3) of Pub. L. 95-142 applicable with respect to care and services furnished on or

after Oct. 25, 1977, see section 2(a)(4) of Pub. L. 95-142, set out as a note under section 1395g of this title.

Section 2(b)(2) of Pub. L. 95-142 provided that: "The amendments made by paragraph (1) [amending this section] shall apply to calendar quarters beginning on and after July 1, 1978, with respect to State plans approved under title XIX of the Social Security Act [this subchapter]."

Amendment by section 3(c)(1) of Pub. L. 95-142 effective Jan. 1, 1978, see section 3(e) of Pub. L. 95-142, set out as an Effective Date note under section 1320a-3 of this title.

Section 7(c)(2) of Pub. L. 95-142 provided that: "The amendment made by subsection (b) [amending this section] shall become effective on January 1, 1978."

Section 19(c)(2) of Pub. L. 95-142 provided that:

"(A) The amendments made by subsection (b) [amending this section and section 1395x of this title] shall apply with respect to operations of a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established (under section 1121(a) of the Social Security Act) [section 1320a(a) of this title] for that type of health services facility.

"(B) The amendments made by subsection (b) [amending this section and section 1395x of this title] shall apply, with respect to the operation of a health services facility or organization which is neither a hospital, a skilled nursing facility, nor an intermediate care facility, on and after the first day of its first fiscal year which begins after such date as the Secretary of Health, Education, and Welfare [now Health and Human Services] determines to be appropriate for the implementation of the reporting requirement for that type of facility or organization.

"(C) Except as provided in subparagraphs (A) and (B), the amendments made by subsection (b)(2) [amending this section] shall apply, with respect to State plans approved under title XIX of the Social Security Act [this subchapter], on and after October 1, 1977."

Amendment by section 20(b) of Pub. L. 95-142 effective Oct. 1, 1977, and the Secretary to adjust payments made to States under section 1396b of this title to reflect such amendment, see section 20(c) of Pub. L. 95-142, set out as a note under section 1396b of this title.

EFFECTIVE DATE OF 1976 AMENDMENT

Section 2 of Pub. L. 94-552 provided that: "The amendments made by the first section [amending this section and section 1395b of this title] shall take effect as of January 1, 1976."

EFFECTIVE DATE OF 1975 AMENDMENT

Section 111(c) of Pub. L. 94-182 provided that: "The amendments made by this section [amending this section and section 1396b of this title] shall (except as otherwise provided for therein) become effective January 1, 1976."

EFFECTIVE DATE OF 1974 AMENDMENT

Section 9(b) of Pub. L. 93-368 provided that: "The amendment made by subsection (a) [amending this section] shall be effective January 1, 1973."

EFFECTIVE DATE OF 1973 AMENDMENT

Section 13(d) of Pub. L. 93-233 provided that: "The amendments made by subsection (a) [amending this section and sections 1396, 1396b, and 1396d of this title] shall be effective with respect to payments under section 1903 of the Social Security Act [section 1396b of this title] for calendar quarters commencing after December 31, 1973."

Section 18(z-3)(4) of Pub. L. 93-233 provided that: "The amendments made by subsections (c) and (u) [amending this section and section 1396b of this title] shall be effective July 1, 1973".

EFFECTIVE DATE OF 1972 AMENDMENT

Section 208(b) of Pub. L. 92-603 provided that: "The amendment made by subsection (a) [amending this section] shall be effective January 1, 1973 (or earlier if the State plan so provided)."

Section 209(b)(2) of Pub. L. 92-603 provided that: "The amendment made by this subsection [amending this section] shall become effective on January 1, 1974."

Section 232(c) of Pub. L. 92-603 provided that: "The amendments made by this section [amending this section and section 705 of this title] shall be effective July 1, 1972 (or earlier if the State plan so provides)."

Amendment by section 236(b) of Pub. L. 92-603 effective Jan. 1, 1973, or earlier if the State plan so provides, see section 236(c) of Pub. L. 92-603, set out as a note under section 1396u of this title.

Section 237(d)(2) of Pub. L. 92-603 provided that: "The amendment made by subsection (a)(2) [amending this section] shall be effective July 1, 1973."

Section 239(d) of Pub. L. 92-603 provided that: "The amendments made by this section [amending this section and section 705 of this title] shall be effective January 1, 1973 (or earlier if the State plan so provides)."

Amendment by section 246(a) of Pub. L. 92-603 to be effective July 1, 1973, see section 246(c) of Pub. L. 92-603, set out as a note under section 1396x of this title.

Section 255(b) of Pub. L. 92-603 provided that: "The amendments made by subsection (a) [amending this section] shall be effective July 1, 1973."

Section 268(c) of Pub. L. 92-603 provided that: "The amendments made by this section [amending this section and section 1396g of this title] shall be effective on the date of the enactment of this Act [Oct. 30, 1972]."

Amendment by section 299D(b) of Pub. L. 92-603 effective beginning Jan. 1, 1973, or within 6 months following Oct. 30, 1972, whichever is later, see section 299D(c) of Pub. L. 92-603, set out as a note under section 1395aa of this title.

EFFECTIVE DATE OF 1971 AMENDMENT

Section 4(d) of Pub. L. 92-223, as amended by section 292 of Pub. L. 92-603, provided that: "The amendments made by this section [amending this section and section 1396d of this title and repealing section 1320a of this title] shall become effective January 1, 1972; except that the repeal made by subsection (c) [repealing section 1320a of this title], shall not become effective in the case of any State, which on January 1, 1972 did not have in effect a State plan approved under title XIX of the Social Security Act [this subchapter], until the first day of the first month (occurring after such date) that such State does have in effect a State plan approved under such title [this subchapter]."

EFFECTIVE DATE OF 1968 AMENDMENT

Amendment by section 210(a)(6) of Pub. L. 90-248 effective July 1, 1969, or, if earlier (with respect to a State's plan approved under this subchapter) on the date as of which the modification of the State plan to comply with such amendment is approved, see section 210(b) of Pub. L. 90-248, set out as a note under section 302 of this title.

Section 223(b) of Pub. L. 90-248 provided that: "The amendments made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1967."

Section 224(b) of Pub. L. 90-248 provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to calendar quarters beginning after December 31, 1967."

Section 224(c)(2) of Pub. L. 90-248 provided that: "The amendment made by paragraph (1) of this subsection [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1970."

Section 227(b) of Pub. L. 90-248, as amended by section 271A of Pub. L. 92-603, effective from and after July 1, 1972, provided that: "The amendments made by this section [amending this section] shall apply with respect to calendar quarters beginning after June 30, 1969;

except that such amendments shall apply in the case of Puerto Rico, the Virgin Islands, and Guam only with respect to calendar quarters beginning after June 30, 1975."

Section 229(b) of Pub. L. 90-248 provided that: "The amendment made by subsection (a) [amending this section] shall apply with respect to legal liabilities of third parties arising after March 31, 1968."

Section 234(b) of Pub. L. 90-248 provided that: "The amendments made by subsection (a) of this section [amending this section] (unless otherwise specified in the body of such amendments) shall take effect on January 1, 1969."

Section 235(b) of Pub. L. 90-248 provided that: "The amendments made by subsection (a) [amending this section] shall be effective in the case of calendar quarters beginning after December 31, 1967."

Enactment by section 236(a) of Pub. L. 90-248 effective July 1, 1970, except as otherwise specified in the text thereof, see section 236(c) of Pub. L. 90-248, set out as an Effective Date note under section 1396g of this title.

Section 237 of Pub. L. 90-248 provided that the amendment made by that section is effective Apr. 1, 1968.

Section 238 of Pub. L. 90-248 provided that the amendment made by that section is effective July 1, 1969.

REGULATIONS

Section 9503(c) of Pub. L. 99-272 provided that: "The Secretary of Health and Human Services shall promulgate final regulations necessary to carry out sections 1902(a)(25) and 1903(x)(6)(J) of the Social Security Act [subsec. (a)(25) of this section and section 1396b(x)(6)(J) of this title] within 6 months after the date of the enactment of this Act [Apr. 7, 1986]."

CONSTRUCTION OF 2009 AMENDMENT

Pub. L. 111-5, div. B, title V, §5008(e)(3), Feb. 17, 2009, 123 Stat. 511, provided that: "Nothing in the amendments made by this subsection [amending this section and section 1397gg of this title] shall be construed as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary of Health and Human Services or by any State with respect to the provision of health care to Indians."

CONSTRUCTION OF 1999 AMENDMENT

Pub. L. 106-169, title I, §121(c), Dec. 14, 1999, 113 Stat. 1830, provided that: "If the Ticket to Work and Work Incentives Improvement Act of 1999 [Pub. L. 106-170] is enacted (whether before, on, or after the date of the enactment of this Act)—

"(1) the amendments made by that Act [see Tables for classification] shall be executed as if this Act [see Short Title of 1999 Amendment note under section 1305 of this title] had been enacted after the enactment of such other Act;

"(2) with respect to subsection (a)(1)(A) of this section [amending this section], any reference to subclause (XIII) is deemed a reference to subclause (XV);

"(3) with respect to subsection (a)(1)(B) of this section [amending this section], any reference to subclause (XIV) is deemed a reference to subclause (XVI);

"(4) [Amended this section.]

"(5) [Amended section 1396d of this title.]"

TRANSFER OF FUNCTIONS

Functions, powers, and duties of Secretary of Health and Human Services under subsec. (a)(4)(A) of this section, insofar as relates to the prescription of personnel standards on a merit basis, transferred to Office of Personnel Management, see section 4726(a)(3)(D) of this title.

REPORTS TO CONGRESS

Pub. L. 111-148, title II, §2001(d)(2), Mar. 23, 2010, 124 Stat. 278, provided that: "Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate."

DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION

Pub. L. 111-148, title II, §2704, Mar. 23, 2010, 124 Stat. 323, provided that:

"(a) AUTHORITY TO CONDUCT PROJECT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a demonstration project under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary—

"(A) with respect to an episode of care that includes a hospitalization; and

"(B) for concurrent physicians services provided during a hospitalization.

"(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

"(b) REQUIREMENTS.—The demonstration project shall be conducted in accordance with the following:

"(1) The demonstration project shall be conducted in up to 8 States, determined by the Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State selected to participate in the demonstration project may target the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State, but the Secretary shall insure [sic] that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

"(2) The demonstration project shall focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs selected to participate, as determined by the Secretary.

"(3) A State selected to participate in the demonstration project shall specify the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also vary such factors among the different States participating in the demonstration project.

"(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional cost sharing than if their care had not been subject to payment under the demonstration project.

"(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

"(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to pay-

ment under the demonstration project being provided with less items and services for which medical assistance is provided under the State Medicaid program than the items and services for which medical assistance would have been provided to such beneficiaries under the State Medicaid program in the absence of the demonstration project.

"(c) WAIVER OF PROVISIONS.—Notwithstanding section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)), the Secretary may waive such provisions of titles XIX, XVIII, and XI of that Act [42 U.S.C. 1396 et seq., 1395 et seq., 1301 et seq.] as may be necessary to accomplish the goals of the demonstration, ensure beneficiary access to acute and post-acute care, and maintain quality of care.

"(d) EVALUATION AND REPORT.—

"(1) DATA.—Each State selected to participate in the demonstration project under this section shall provide to the Secretary, in such form and manner as the Secretary shall specify, relevant data necessary to monitor outcomes, costs, and quality, and evaluate the rationales for selection of the episodes of care and services specified by States under subsection (b)(3).

"(2) REPORT.—Not later than 1 year after the conclusion of the demonstration project, the Secretary shall submit a report to Congress on the results of the demonstration project."

PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT

Pub. L. 111-148, title II, §2706, Mar. 23, 2010, 124 Stat. 325, provided that:

"(a) AUTHORITY TO CONDUCT DEMONSTRATION.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act [42 U.S.C. 1395jjj] (as added by section 3022).

"(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

"(b) APPLICATION.—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(c) REQUIREMENTS.—

"(1) PERFORMANCE GUIDELINES.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

"(2) SAVINGS REQUIREMENT.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] and the CHIP program under title XXI of such Act [42 U.S.C. 1397aa et seq.] that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

"(3) MINIMUM PARTICIPATION PERIOD.—A provider desiring to be recognized as an accountable care organization under the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

"(d) INCENTIVE PAYMENT.—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section."

MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT

Pub. L. 111-148, title II, §2707, Mar. 23, 2010, 124 Stat. 326, provided that:

"(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish a demonstration project under which an eligible State (as described in subsection (c)) shall provide payment under the State Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] to an institution for mental diseases that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to individuals who—

"(1) have attained age 21, but have not attained age 65;

"(2) are eligible for medical assistance under such plan; and

"(3) require such medical assistance to stabilize an emergency medical condition.

"(b) STABILIZATION REVIEW.—A State shall specify in its application described in subsection (c)(1) establish [sic] a mechanism for how it will ensure that institutions participating in the demonstration will determine whether or not such individuals have been stabilized (as defined in subsection (f)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of services for the stabilization of medical emergency conditions through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

"(c) ELIGIBLE STATE DEFINED.—

"(1) IN GENERAL.—An eligible State is a State that has made an application and has been selected pursuant to paragraphs (2) and (3).

"(2) APPLICATION.—A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances, as the Secretary may require.

"(3) SELECTION.—A State shall be determined eligible for the demonstration by the Secretary on a competitive basis among States with applications meeting the requirements of paragraph (1). In selecting State applications for the demonstration project, the Secretary shall seek to achieve an appropriate national balance in the geographic distribution of such projects.

"(d) LENGTH OF DEMONSTRATION PROJECT.—The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

"(e) LIMITATIONS ON FEDERAL FUNDING.—

"(1) APPROPRIATION.—

"(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2011.

"(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act [sic] and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

"(2) 5-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2015.

"(3) LIMITATION ON PAYMENTS.—In no case may—

"(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $75,000,000; or

"(B) payments be provided by the Secretary under this section after December 31, 2015.

"(4) FUNDS ALLOCATED TO STATES.—Funds shall be allocated to eligible States on the basis of criteria, including a State's application and the availability of funds, as determined by the Secretary.

"(5) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State, from its allocation under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a). As a condition of receiving payment, a State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight and conducting an evaluation under subsection (f)(1).

"(f) EVALUATION AND REPORT TO CONGRESS.—

"(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration project in order to determine the impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program and shall include the following:

"(A) An assessment of access to inpatient mental health services under the Medicaid program; average lengths of inpatient stays; and emergency room visits.

"(B) An assessment of discharge planning by participating hospitals.

"(C) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care).

"(D) An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

"(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2015, and expanded on a national basis.

"(2) REPORT.—Not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

"(g) WAIVER AUTHORITY.—

"(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

"(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act [42 U.S.C. 1301 et seq., 1396 et seq.] (including the requirements of sections 1902(a)(1) [42 U.S.C. 1396a(a)(1)] (relating to statewideness) and 1902(1)(10)(B) [probably means 1902(a)(1)(10)(B), 42 U.S.C. 1396a(a)(1)(10)(B)] (relating to comparability)) only to [the] extent necessary to carry out the demonstration project under this section.

"(h) DEFINITIONS.—In this section:

"(1) EMERGENCY MEDICAL CONDITION.—The term 'emergency medical condition' means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

"(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' has the meaning given that term with respect to a State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

"(3) INSTITUTION FOR MENTAL DISEASES.—The term 'institution for mental diseases' has the meaning given to that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

"(4) MEDICAL ASSISTANCE.—The term 'medical assistance' has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

"(5) STABILIZED.—The term 'stabilized' means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

"(6) STATE.—The term 'State' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)."

INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID

Pub. L. 111-148, title IV, § 4108, Mar. 23, 2010, 124 Stat. 561, provided that:

"(a) INITIATIVES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary [of Health and Human Services] shall award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries who—

"(i) successfully participate in a program described in paragraph (3); and

"(ii) upon completion of such participation, demonstrate changes in health risk and outcomes, including the adoption and maintenance of healthy behaviors by meeting specific targets (as described in subsection (c)(2)).

"(B) PURPOSE.—The purpose of the initiatives under this section is to test approaches that may encourage behavior modification and determine scalable solutions.

"(2) DURATION.—

"(A) INITIATION OF PROGRAM; RESOURCES.—The Secretary shall awards grants to States beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. The Secretary shall develop program criteria for initiatives under this section using relevant evidence-based research and resources, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs and Practices.

"(B) DURATION OF PROGRAM.—A State awarded a grant to carry out initiatives under this section shall carry out such initiatives within the 5-year period beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. Initiatives under this section shall be carried out by a State for a period of not less than 3 years.

"(3) PROGRAM DESCRIBED.—

"(A) IN GENERAL.—A program described in this paragraph is a comprehensive, evidence-based, widely available, and easily accessible program, proposed by the State and approved by the Secretary, that is designed and uniquely suited to address the needs of Medicaid beneficiaries and has demonstrated success in helping individuals achieve one or more of the following:

"(i) Ceasing use of tobacco products.

"(ii) Controlling or reducing their weight.

"(iii) Lowering their cholesterol.

"(iv) Lowering their blood pressure.

"(v) Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

"(B) CO-MORBIDITIES.—A program under this section may also address co-morbidities (including depression) that are related to any of the conditions described in subparagraph (A).

"(C) WAIVER AUTHORITY.—The Secretary may waive the requirements of section 1902(a)(1) (relating to statewideness) of the Social Security Act [42

U.S.C. 1396a(a)(1)] for a State awarded a grant to conduct an initiative under this section and shall ensure that a State makes any program described in subparagraph (A) available and accessible to Medicaid beneficiaries.

"(D) FLEXIBILITY IN IMPLEMENTATION.—A State may enter into arrangements with providers participating in Medicaid, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities or organizations to carry out programs described in subparagraph (A).

"(4) APPLICATION.—Following the development of program criteria by the Secretary, a State may submit an application, in such manner and containing such information as the Secretary may require, that shall include a proposal for programs described in paragraph (3)(A) and a plan to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware and informed about such programs.

"(b) EDUCATION AND OUTREACH CAMPAIGN.—

"(1) STATE AWARENESS.—The Secretary shall conduct an outreach and education campaign to make States aware of the grants under this section.

"(2) PROVIDER AND BENEFICIARY EDUCATION.—A State awarded a grant to conduct an initiative under this section shall conduct an outreach and education campaign to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware of the programs described in subsection (a)(3) that are to be carried out by the State under the grant.

"(c) IMPACT.—A State awarded a grant to conduct an initiative under this section shall develop and implement a system to—

"(1) track Medicaid beneficiary participation in the program and validate changes in health risk and outcomes with clinical data, including the adoption and maintenance of health behaviors by such beneficiaries;

"(2) to the extent practicable, establish standards and health status targets for Medicaid beneficiaries participating in the program and measure the degree to which such standards and targets are met;

"(3) evaluate the effectiveness of the program and provide the Secretary with such evaluations;

"(4) report to the Secretary on processes that have been developed and lessons learned from the program; and

"(5) report on preventive services as part of reporting on quality measures for Medicaid managed care programs.

"(d) EVALUATIONS AND REPORTS.—

"(1) INDEPENDENT ASSESSMENT.—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the initiatives carried out by States under this section, for the purpose of determining—

"(A) the effect of such initiatives on the use of health care services by Medicaid beneficiaries participating in the program;

"(B) the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;

"(C) the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and

"(D) the administrative costs incurred by State agencies that are responsible for administration of the program.

"(2) STATE REPORTING.—A State awarded a grant to carry out initiatives under this section shall submit reports to the Secretary, on a semi-annual basis, regarding the programs that are supported by the grant funds. Such report shall include information, as specified by the Secretary, regarding—

"(A) the specific uses of the grant funds;

"(B) an assessment of program implementation and lessons learned from the programs;

"(C) an assessment of quality improvements and clinical outcomes under such programs; and

"(D) estimates of cost savings resulting from such programs.

"(3) INITIAL REPORT.—Not later than January 1, 2014, the Secretary shall submit to Congress an initial report on such initiatives based on information provided by States through reports required under paragraph (2). The initial report shall include an interim evaluation of the effectiveness of the initiatives carried out with grants awarded under this section and a recommendation regarding whether funding for expanding or extending the initiatives should be extended beyond January 1, 2016.

"(4) FINAL REPORT.—Not later than July 1, 2016, the Secretary shall submit to Congress a final report on the program that includes the results of the independent assessment required under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

"(e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, MEDICAID OR OTHER BENEFITS.—Any incentives provided to a Medicaid beneficiary participating in a program described in subsection (a)(3) shall not be taken into account for purposes of determining the beneficiary's eligibility for, or amount of, benefits under the Medicaid program or any program funded in whole or in part with Federal funds.

"(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the 5-year period beginning on January 1, 2011, $100,000,000 to the Secretary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

"(g) DEFINITIONS.—In this section:

"(1) MEDICAID BENEFICIARY.—The term 'Medicaid beneficiary' means an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and is enrolled in such plan or waiver.

"(2) STATE.—The term 'State' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)."

COORDINATION OF EXPANSION OF THE RECOVERY AUDIT CONTRACTOR PROGRAM; REGULATIONS

Pub. L. 111–148, title VI, §6411(a)(2), Mar. 23, 2010, 124 Stat. 775, provided that:

"(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State's Medicaid program prior to December 31, 2010.

"(B) REGULATIONS.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection [amending this section] and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary."

ANNUAL REPORT

Pub. L. 111–148, title VI, §6411(c), Mar. 23, 2010, 124 Stat. 775, provided that: "The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program under Medicaid and Medicare and shall include [in] such reports recommendations for expanding or improving the program."

PURPOSES OF 2009 AMENDMENT

Pub. L. 111–5, div. B, title V, §5000(a), Feb. 17, 2009, 123 Stat. 496, provided that: "The purposes of this title [en-

acting section 1320b-24 of this title, amending this section and sections 1396o, 1396o-1, 1396p, 1396r-4, 1396r-6, 1396u-2, 1396u-3, and 1397gg of this title, and enacting provisions set out as notes under this section and sections 1396d and 1396r-6 of this title] are as follows:

"(1) To provide fiscal relief to States in a period of economic downturn.

"(2) To protect and maintain State Medicaid programs during a period of economic downturn, including by helping to avert cuts to provider payment rates and benefits or services, and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements."

LIMITATION ON WAIVER AUTHORITY

Pub. L. 111-3, title II, §211(a)(2), Feb. 4, 2009, 123 Stat. 52, provided that: "Notwithstanding any provision of section 1115 of the Social Security Act (42 U.S.C. 1315), or any other provision of law, the Secretary [of Health and Human Services] may not waive the requirements of section 1902(a)(46)(B) of such Act (42 U.S.C. 1396a(a)(46)(B)) with respect to a State."

EXTENSION OF SSI WEB-BASED ASSET DEMONSTRATION PROJECT TO THE MEDICAID PROGRAM

Pub. L. 110-90, §4, Sept. 29, 2007, 121 Stat. 985, which required that an automated, secure, web-based asset verification request and response process be applied to Medicaid's asset eligibility determinations in certain States during a certain period, was repealed by Pub. L. 110-252, title VII, §7001(d)(4), June 30, 2008, 122 Stat. 2394.

DEMONSTRATION PROJECTS REGARDING HOME AND COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN

Pub. L. 109-171, title VI, §6083, Feb. 8, 2006, 120 Stat. 89, provided that:

"(a) IN GENERAL.—The Secretary is authorized to conduct, during each of fiscal years 2007 through 2011, demonstration projects (each in the section referred to as a 'demonstration project') in accordance with this section under which up to 10 States (as defined for purposes of title XIX of the Social Security Act [this subchapter]) are awarded grants, on a competitive basis, to test the effectiveness in improving or maintaining a child's functional level and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment for children enrolled in the Medicaid program under title XIX of such Act.

"(b) APPLICATION OF TERMS AND CONDITIONS.—

"(1) IN GENERAL.—Subject to the provisions of this section, for the purposes of the demonstration projects, and only with respect to children enrolled under such demonstration projects, a psychiatric residential treatment facility (as defined in section 483.352 of title 42 of the Code of Federal Regulations) shall be deemed to be a facility specified in section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), and to be included in each reference in such section 1915(c) to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

"(2) STATE OPTION TO ASSURE CONTINUITY OF MEDICAID COVERAGE.—Upon the termination of a demonstration project under this section, the State that conducted the project may elect, only with respect to a child who is enrolled in such project on the termination date, to continue to provide medical assistance for coverage of home and community-based alternatives to psychiatric residential treatment for the child in accordance with section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), as modified through the application of paragraph (1). Expenditures incurred for providing such medical assistance shall be treated as a home and community-based waiver program under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) for purposes of payment under section 1903 of such Act (42 U.S.C. 1396b).

"(c) TERMS OF DEMONSTRATION PROJECTS.—

"(1) IN GENERAL.—Except as otherwise provided in this section, a demonstration project shall be subject to the same terms and conditions as apply to a waiver under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), including the waiver of certain requirements under the first sentence of paragraph (3) of such section but not applying the second sentence of such paragraph.

"(2) BUDGET NEUTRALITY.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) do not exceed the amount which the Secretary estimates would have been paid under that title if the demonstration projects under this section had not been implemented.

"(3) EVALUATION.—The application for a demonstration project shall include an assurance to provide for such interim and final evaluations of the demonstration project by independent third parties, and for such interim and final reports to the Secretary, as the Secretary may require.

"(d) PAYMENTS TO STATES; LIMITATIONS TO SCOPE AND FUNDING.—

"(1) IN GENERAL.—Subject to paragraph (2), a demonstration project approved by the Secretary under this section shall be treated as a home and community-based waiver program under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) for purposes of payment under section 1903 of such Act (42 U.S.C. 1396b).

"(2) LIMITATION.—In no case may the amount of payments made by the Secretary under this section for State demonstration projects for a fiscal year exceed the amount available under subsection (f)(2)(A) for such fiscal year.

"(e) SECRETARY'S EVALUATION AND REPORT.—The Secretary shall conduct an interim and final evaluation of State demonstration projects under this section and shall report to the President and Congress the conclusions of such evaluations within 12 months of completing such evaluations.

"(f) FUNDING.—

"(1) IN GENERAL.—For the purpose of carrying out this section, there are appropriated, from amounts in the Treasury not otherwise appropriated, for fiscal years 2007 through 2011, a total of $218,000,000, of which—

"(A) the amount specified in paragraph (2) shall be available for each of fiscal years 2007 through 2011; and

"(B) a total of $1,000,000 shall be available to the Secretary for the evaluations and report under subsection (e).

"(2) FISCAL YEAR LIMIT.—

"(A) IN GENERAL.—For purposes of paragraph (1), the amount specified in this paragraph for a fiscal year is the amount specified in subparagraph (B) for the fiscal year plus the difference, if any, between the total amount available under this paragraph for prior fiscal years and the total amount previously expended under paragraph (1)(A) for such prior fiscal years.

"(B) FISCAL YEAR AMOUNTS.—The amount specified in this subparagraph for—

"(i) fiscal year 2007 is $21,000,000;

"(ii) fiscal year 2008 is $37,000,000;

"(iii) fiscal year 2009 is $49,000,000;

"(iv) fiscal year 2010 is $53,000,000; and

"(v) fiscal year 2011 is $57,000,000."

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION

Pub. L. 109-171, title VI, §6071, Feb. 8, 2006, 120 Stat. 102, as amended by Pub. L. 111-148, title II, §2403(a), (b)(1), Mar. 23, 2010, 124 Stat. 304, 305, provided that:

"(a) PROGRAM PURPOSE AND AUTHORITY.—The Secretary is authorized to award, on a competitive basis, grants to States in accordance with this section for

29 U.S.C. § 794a(2) (emphasis added).

1.[2] The anti-retaliation provision of Title VI of the Civil Rights Act incorporated by section 504 states:

No recipient or other person shall intimidate, threaten, coerce, or discriminate against any individual for the purpose of interfering with any right or privilege secured by Section 601 of [the Civil Rights] Act or this part, or because he has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under this part.

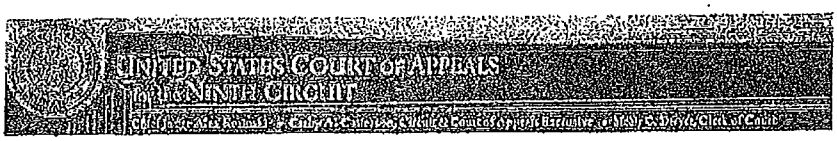
34 C.F.R. § 100.7(e) (emphasis added).

CEC Policy Insider

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11/17/2009

Ninth Circuit Clarifies Section 504 and the ADA's Anti-Retaliation Provisions



In a highly anticipated decision, the United States Court of Appeals for the Ninth Circuit ruled that a teacher, who alleged she was constructively terminated for raising concerns about how her district served special education students, could sue the District under the anti-retaliation provisions of Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

Susan Lee Barker, a Resource Specialist Program teacher, raised concerns to her supervisors that her District's special education services failed to comply with federal and state law. In addition, she filed a class discrimination complaint with the U.S. Office of Civil Rights alleging the District denied students with disabilities a right to FAPE. After this, Barker alleged the District began retaliating against her by intimidating her, failing to respond to her emails and calls, excluding her from important staff meetings, changing her work assignments in an unfavorable way, reducing her caseload despite increasing enrollment, and refusing to allow her certain work assignments arbitrarily.

The Ninth Circuit's opinion did not determine whether these incidents occurred or whether they constituted retaliation or constructive termination. Instead, the Court's decision focused entirely on whether, under Section 504 and the ADA, Barker had a right to sue. The first court to consider the matter, the United States District Court, determined that Section 504 and the ADA only allowed a qualified individual with a disability to sue; thus, because Barker was not disabled it barred her claims. She appealed and ultimately, the Ninth Circuit reversed the lower court. It ruled that each statute specifically included an anti-retaliation provision which allowed "any individual" to sue, not just individuals with disabilities. The case will now return to the District Court for a trial on the merits.

It is not known whether the District will appeal the Ninth Circuit's decision to the U.S. Supreme Court. But the decision clarifies and expands an employee's ability to sue her employer in a significant way and could have far reaching ramifications for districts and employees throughout nation. Based on these implications, CEC is monitoring the proceedings and will continue to provide information about this case on its Policy Blog.

Read the Court's decision here: http://caselaw.lp.findlaw.com/data2/circs/9th/0756313p.pdf

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PRE-ADMISSION, SCREENING AND ANNUA REVIEW (PASRR) PROGRAM

HISTORY AND BACKGROUND OF THE PASRR PRC

The United States Congress created the Pre-Admission Scree Review (PASRR) program under the Omnibus Budget Reconcilia 1987, primarily out of concern that, as a result of the deinstitutiona many people with "Serious Mental Illness" (SMI) or "Develo Disabilities" were being inappropriately placed in nursing facilitie would not receive the care or specialized services they needed.

Section 42 of the Code of Federal Regulations (42 CFR) speci state Medicaid agency to include a PASRR program in their develop a written agreement with the state mental health a developmental/intellectual disabilities authority, both of which in the Division of Mental Health and Developmental Services (MH operation of the PASRR program.

In Nevada, MHDS teams with the state Medicaid and the Neva Improvement Organization (QIO-like vendor), to assure the proper monitoring, in collaboration with federal regulations and requireme PASRR program.

MHDS PASRR RESPONSIBILITIES AND SERVIC

MHDS Administrative Central Office

- Administrative oversight of the federally mandated PASRR res state's mental health and developmental/intellectual services aut
- Conducts bi-annual Nevada PASRR Program Compliance F PASRR QIO-like vendor, 2) PASRR clients requiring special reside in nursing facilities, and 3) MHDS' statewide regional PAS

TEXAS
Department of Aging
and Disability Services

COMMISSIONER
Chris Traylor

January 25, 2011

To: Nursing Facility Administrators, Social Workers, and Rehabilitation Therapy Staff

Subject: Information Letter No. 11-11
Availability of Specialized Services in Medicaid Nursing Facilities

The Department of Aging and Disability Services (DADS) has identified a need to provide clarification to facilities regarding the provision of specialized services to Medicaid-eligible nursing facility residents, and the relation of specialized services to Preadmission Screening and Resident Review (PASRR). PASRR is a federally-mandated program that requires any person, regardless of payment source, seeking admission into a Medicaid-certified nursing facility (NF) to be assessed for a diagnosis of mental illness, intellectual disability (ID) or a developmental disability (DD) (also known as a "related condition").

Eligibility for Specialized Services

To be eligible for specialized services, a Medicaid recipient must:
- be Medicaid eligible for NF care;
- reside in a Medicaid-certified NF; and
- have an approved PASRR Level II.

When a resident receives approval of a PASRR Level II, they are eligible for the benefit of specialized services. Specialized services include physical therapy (PT), occupational therapy (OT), speech therapy (SP), customized manual wheelchair (CMWC), durable medical equipment (DME), alternate placement services, and vocational training. These services are provided through either the NF or a local MR authority (MRA), depending on the service.

Specialized Services Provided by the MRA

The specialized services available through and billed to DADS by a MRA include:
- service coordination (SC);
- determination of intellectual disability (DMR);
- alternate placement services; and
- vocational training.

Service coordination includes supports, and coordination of supports, that help a resident achieve a quality of life and community participation acceptable to the resident as described in the resident's plan of care. These supports include assessments, service planning, monitoring, crisis prevention, and crisis management. Alternate placement service is assistance provided to an eligible nursing facility resident to locate and secure services chosen by the resident or legally authorized representative (LAR) to meet the resident's basic needs in a setting other than a nursing facility. Vocational training is training service provided to a nursing facility resident in an industrial enclave, a work crew, a sheltered workshop or an affirmative industry to enable the

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resident to obtain employment. A DMR is an interview and assessment, or an endorsement, conducted in accordance with Health and Safety Code, §593.005, and 40 Texas Administrative Code Chapter 5, Subchapter D to determine if an individual has an ID or is a member of the ID priority population.

In order to facilitate the provision of these services to a resident DADS sends the MRA, via encrypted e-mail, referral information related to an individual seeking admission to a NF who has a diagnosis of ID or DD and who has been assessed as eligible for NF medical necessity and specialized services through the completion of a PASRR Level II assessment. MRA staff will retrieve the referral and ensure a service coordinator contacts the resident within 120 days after the referral is sent to the MRA.

The service coordinator will contact the resident and complete an assessment, which will:
- verify the individual is residing in an NF in the MRA's local service area;
- review all available records to determine if the resident has a diagnosis of ID or DD; and
- secure the resident's decision regarding participation in the specialized services offered through the MRA.

Specialized Services Provided/Coordinated by the NF

Once the resident is confirmed as eligible to receive specialized services, the resident may request, and the NF must provide the following specialized services if ordered by a physician:
- PT;
- OT;
- SP;
- CMWC; and
- DME.

Specialized services provided through the NF are billed to and paid by DADS separately from the Medicaid daily rate. All specialized services must be prior authorized by DADS with the exception of one evaluation per diagnosis, injury or illness towards which the therapy is targeted. Any specialized services provided without prior authorization (except as stated previously) will not be reimbursed by DADS.

The NF must obtain approval for the provision of specialized services by using the following forms:
- Form 2465, Specialized Services Request - for PT, OT and SP requests;
- Form 1017, Specialized Services Durable Medical Equipment Authorization Request - for DME requests; and
- Form 1018, Specialized Services Customized Manual Wheelchair Authorization Request - for CMWC requests.

For additional information regarding:
- PASRR, go to:
  - Preadmission Screening and Resident Review (DADS);

- submission of Form 2465, go to:
  - http://www.dads.state.tx.us/providers/communications/2010/letters/IL2010-03.pdf; and
  - http://www.dads.state.tx.us/providers/communications/2009/letters/IL2009-10.pdf;
- submission of Forms 1017 and 1018 go to:
  - http://www.dads.state.tx.us/providers/communications/2010/letters/IL2010-50.pdf; and
- specialized services provided through the MRA, go to:
  - DADS Mental Retardation Authority Omnibus Budget Reconciliation Act Preadmission Screening and Resident Review Handbook - Table of Contents.

If you have any questions or need additional information, Sean Ivie, Lead Policy Analyst, serves as the lead staff on matters regarding CMWC and DME, and can be reached by phone at (512) 438-5208 or by e-mail at Sean.Ivie@dads.state.tx.us. Jamie White, Policy Analyst, serves as lead staff on matters regarding PASRR and can be reached at (512) 438-4431 or by email at Jamie.White@dads.state.tx.us. For questions regarding Form 2465 and the authorization process for PT, OT and SP services, contact Provider Claims Services by phone at (512) 438-2200 (select option 6). Robert Evans, MRA Unit Manager, serves as the lead staff on matters regarding specialized services provided through the MRA, and can be reached by phone at (512) 438-2140 or by email at Robert.Evans@dads.state.tx.us.

Sincerely,

[signature on file]

Geri Willems
Manager
MERP/PASRR

Click here to find services for you, your family or someone you are caring for.

Preadmission Screening and Resident Review (PASARR)

Effective Sept. 1, 2008, DADS converted the current reimbursement methodology from the Texas Index for Level of Effort (TILE) to the federal Resource Utilization Groups (RUGS).

Associated with these changes, DADS has implemented a new Preadmission Screening and Resident Review (PASARR) process. Training on these new processes began June 2008, and continue to occur across the state.

PASARR is a federally-mandated program that requires any person, regardless of payment source, seeking admission into a Medicaid-certified nursing facility to be assessed for a diagnosis of mental illness, mental retardation or a related condition. If there are indications as to these diagnoses, a PASARR Screening Form must be completed by the nursing facility and submitted to the Texas Medicaid and Healthcare Partnership (TMHP) via the Long Term Care (LTC) online portal prior to admission.

This screening will be assessed and a determination made by TMHP as to whether the individual meets medical necessity for a nursing facility level of care and if the individual might benefit from specialized services. The nursing facility will receive the medical necessity determination notice via the LTC online portal and written notice also will be sent to the individual, attending physician, nursing facility and the responsible party (as appropriate). It is strongly recommended that copies of all PASARR Screening Forms be maintained in the individuals' medical record.

For non-Medicaid enrolled individuals seeking admission into a Medicaid-certified nursing facility, who are suspected of having mental illness, mental retardation or a related condition, the nursing facility must complete the PASARR Screening Form and place a copy in the individual's medical file.

NOTE: The PASARR Screening Form is only used when an individual is suspected of having mental illness, mental retardation or a related condition. You do not need to fill this form out if there is no indication of these diagnoses.

Helpful links

- DADS Provider Communications website
- DADS TILEs to RUGs website
- Texas Medicaid Health Care Partnership (TMHP) website

Updated: September 8, 2011

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin
Department of Health and Social Services

DIVISION OF HEALTH
1 WEST WILSON STREET
P. O. BOX 309
MADISON WI 53701-0309

MEMORANDUM

DATE: January 11, 1996

TO: Nursing Homes

FROM: K. S. Piper, Director
Bureau of Health Care Financing

SUBJECT: Wisconsin Medicaid Provider Handbook, Part Y

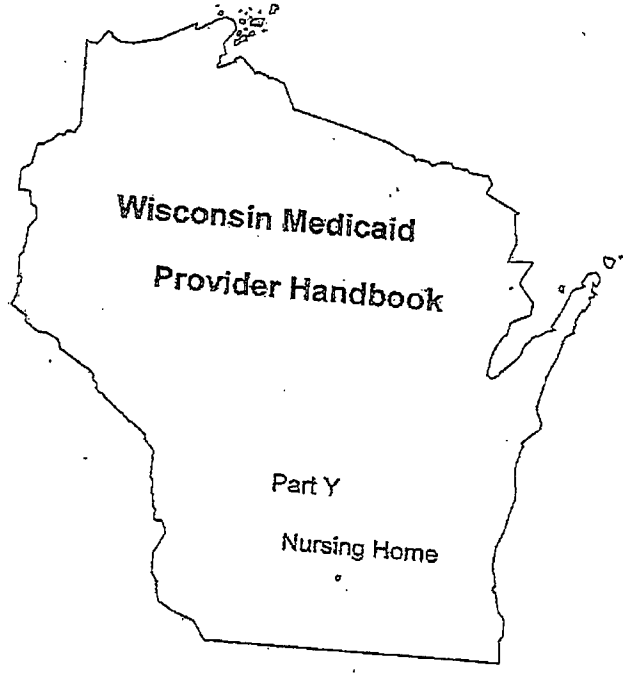
Enclosed is the new Wisconsin Medicaid nursing home handbook. Handbook drafts were shared and thoroughly discussed with the Wisconsin Health Care Association and Wisconsin Association of Homes and Services for the Aging.

This handbook includes information on provider certification requirements, covered service requirements, and billing instructions. Use this handbook along with HSS 101-108, Wisconsin Administrative Code, and Wisconsin Medicaid Updates. Keep this handbook as a reference tool. Future updates to this handbook will occur as handbook replacement pages.

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Enclosure

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Part Y
Nursing Home Services
Transmittal Log

This log is designed as a convenient record sheet for recording receipt of handbook updates. Providers must delete old pages and insert new pages as instructed. Use of this log helps eliminate errors and ensures an up-to-date handbook.

Each update to Part Y of the handbook is numbered sequentially. This sequential numbering system alerts the provider to any updates not received. For example, if the last transmittal number on your log is Y-3 and you receive Y-5, you are missing Y-4. If a provider is missing a transmittal, copies of complete provider handbooks may be purchased by writing to the address in Appendix 36 of Part A, the all-provider handbook.

Transmittal Number	Initials	Issue Date

Nursing Home Services
Part Y

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A. Type of Handbook

Part Y, Nursing Home Services, is the service-specific portion of the Wisconsin Medicaid Provider Handbook. Part Y includes information on provider eligibility criteria, recipient eligibility criteria, covered services, reimbursement and billing instructions. Use Part Y in conjunction with Part A of the Wisconsin Medicaid Provider Handbook which has general policy guidelines, regulations, and billing information for all providers certified in Wisconsin Medicaid. Nursing homes should use Part N of the provider handbook which contains the information on Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS), including covered services and prior authorization for specialized wheelchairs, respiratory equipment, and exceptional supplies for nursing home recipients.

Note: This handbook has references to various organizational units of the Department of Health and Social Services (DHSS), Division of Health (DOH), Bureau of Health Care Financing (BHCF). The DHSS is the designated single state agency for administration of the Medicaid program in Wisconsin; and the BHCF is the designated State Medicaid Agency for overall program administration. A copy of a current organization chart is available upon request.

B. Provider Information

Nursing Homes – General Definitions

Nursing home is defined in Chapter 50, Wis. Statutes, as: "a place which provides 24-hour services including board and room to three or more unrelated residents who because of their mental or physical condition require nursing care or personal care in excess of seven hours a week." Nursing homes participating in Medicaid are called nursing facilities (NFs). Nursing homes which also participate in Medicare are called skilled nursing facilities (SNFs). Facilities, or their distinct parts, which predominantly serve the developmentally disabled are called intermediate care facilities for the mentally retarded (ICF-MRs) or facilities for the developmentally disabled (FDDs).

Provider Eligibility and Certification

Wisconsin Medicaid certifies nursing homes to provide skilled and intermediate care. Under Wisconsin Medicaid, all NFs, ICF-MRs, or FDDs must be licensed according to s. 50.03, Wis. Stats. by the Bureau of Quality Compliance (BQC) in the Department of Health and Social Services (DHSS). Additional Medicaid certification requirements are:

1. SNFs which are also certified as an NF must meet the requirements for participation in Medicare as well as those specifically stated in HSS 105.08, 105.09, and 132, Wis. Admin. Code. These Medicaid requirements include the Medicare bed requirements defined in s. 49.45(10) and 50.02(2), Wis. Stats.
2. ICF-MRs providing services to the developmentally disabled must meet the certification requirements stated in HSS 105.12 and 134, Wis. Admin. Code.

Providers interested in certification requirements specific to NFs or FDDs should contact the BQC. Refer to Appendix 22 of this handbook for the BQC addresses, including district offices.

Scope of Service

The policies in Part Y govern services provided within the scope of the practice of the profession as defined in s. 50.01, Wis. Stats., s. 49.45(6m), Wis. Stats. and HSS 107.09, Wis. Admin. Code. Covered services and related limitations are addressed in Section II of this handbook.

B. Provider Information (continued)

Nursing Home Reimbursement

Medicaid-certified nursing homes are reimbursed according to a prospective rate-setting methodology as stipulated in s. 49.45(6m), Wis. Stats. The DHSS establishes this methodology annually. The methodology is called "the formula" or "the Methods of Implementation." The payment formula determines nursing home payment rates for the annual rate year (defined as July 1 through June 30 of each year). The formula is annually transmitted to certified nursing homes by the Bureau of Health Care Financing (BHCF). For rate setting, nursing homes must complete an annual cost report which corresponds to the individual nursing home's fiscal year. In addition, nursing homes must provide other information on the annual formula to determine the actual payment rates.

Generally, the individual nursing home's payment rate from Wisconsin Medicaid is based on the nursing home's allowable costs during the previous 12-month fiscal year period, increased by a projected inflation percentage for the effective rate period (current year), and limited by the nursing home formula parameters. Nursing homes are required to annually submit a twelve-month cost report, and the payment formula is part of the Medicaid State Plan referred to as the annual Methods of Implementation. Medicaid regional auditors set the rates. The addresses of the regional auditors are listed in Appendix21. Questions regarding the actual payment formula should be directed to the Nursing Home Section of the BHCF.

Separate accommodation rates are established for each level of care (medical intensive skilled, head injury skilled, skilled, intermediate nursing care levels and developmentally disabled care levels). A list of the accommodation codes, including bedhold codes, is in Appendix 15 of this handbook. The following Medicaid accommodation codes and their corresponding nursing home care levels are as follows:

Accommodation Code	Care Level
20	Skilled Care
21	Intermediate Care 1 and Intermediate Care 2-Limited
22	Intermediate Care 3-Personal
23	Intermediate Care 4-Residential
25	Intensive Skilled Nursing
26	Developmentally Disabled 1A
27	Developmentally Disabled 1B
28	Developmentally Disabled 2
29	Developmentally Disabled 3
80	Brain Injured (Prior Authorization Required-See Section III)

Intermediate care level three (personal) and care level four (residential) are not reimbursable except for:

- residents who entered a facility before October 1, 1981, and have continuously resided in a health care facility since that date; and
- residents who have a primary diagnosis of developmental disabilities (DD) or chronic mental illness (CMI) and who entered a facility before November 1, 1983, and continuously resided in a nursing home.

B. Provider Information (continued)

Nursing Home Appeals Mechanism

A nursing home appeals mechanism exists under Section 49.45 (6m)(c) of the Wisconsin Statutes. Called the "Nursing Home Appeals Board," its purpose is to review applications from nursing homes for financial relief if demonstrated, substantial inequities exist in the individual nursing home Medicaid rates resulting from the annual nursing home payment formula. The Statute lists various criteria which may qualify a nursing home for appeals mechanism funding.

The Nursing Home Appeals Board is separate from the Chapter 227 administrative hearing process and the Administrative Review Process (below) which both address Wisconsin Medicaid rate decisions. The Appeals Board functions retrospectively following the completion of the rate year. Nursing homes interested in this mechanism must submit a 12-month cost report coinciding with the formula rate year along with an appeal application.

Nursing homes are annually notified through a BHCF Memorandum when the appeal requests are due. Additional information can be obtained by contacting the Wisconsin Medicaid Nursing Home Appeals Auditor, Nursing Home Section, BHCF.

Administrative Review Process

The BHCF has established an administrative review process for nursing home rates calculated by the BHCF regional auditors. This process is different from the formal administrative hearing process described in Chapter 227, Wis. Stats., and from the nursing home appeals mechanism which addresses payment formula inequities.

The purpose of the administrative review process is twofold. The first is to allow nursing homes a vehicle to contest interpretations by Medicaid regional auditors when setting Medicaid nursing home payment rates. According to the Nursing Home Methods of Implementation, a nursing home may request an administrative review of the DHSS' cost finding decisions in the rate-setting process. For example, this could mean a disputed adjustment by the Auditor to costs reported in the annual cost report. The request must be filed within 30 days of the facility's receipt of notification of the Medicaid nursing home proposed rates.

The second purpose of the administrative review process is to develop payment policies and formula interpretations which may be initiated by the BHCF or which may be requested by nursing home providers or their representatives.

The administrative review process uses a review committee composed of the BHCF Nursing Home Section's Chief, one of the Section's Financial Supervisors and the Section's Review Auditor. A staff person from the Nursing Home Section's Policy staff is included in the Administrative Review Process for policy or payment formula interpretations and coordination. The assigned auditor may also be involved in instances of cost finding, allowable cost determinations, or rate disputes. The Administrative Review Committee meets whenever there are rate-setting interpretation requests to review or payment policy/formula interpretations to develop. The committee's decisions are subject to review and approval by the Director of the BHCF.

Requests from nursing homes for Medicaid Auditor interpretations or for policy/formula statements/interpretations may be requested through one of the nursing home associations for represented homes. The association provides initial screening and assists in the review process by assuring valid, complete and adequate requests, including combining multiple requests of a similar nature (i.e. several nursing homes with the same type of request). A nursing home may, also, submit a request directly to the Review Committee through the BHCF Nursing Home Section Chief.

B. Provider Information (continued)

Requests should contain specific data and factual information for consideration and not provide only generalizations. Requests contesting Medicaid Auditor interpretations must also be timely for consideration (within 30 days of the nursing home's receipt of notification of Medicaid rates).

For requested reviews contesting Medicaid Auditor interpretations in rate setting, the request must be submitted within the 30-day time frame; and a decision on the request will be submitted to the association and/or nursing home following the Committee's review and BHCF Director's approval (unless delegated). For payment policy or formal interpretation requested by nursing homes, the Committee will determine whether a policy statement is necessary.

For payment policy and/or formula interpretation development initiated by BHCF or by the Review Committee, a policy statement is drafted and reviewed by BHCF and then submitted to the nursing home associations and the Board on Aging and Long Term Care (BOALTC) for review and comment. The policy statement will include a preliminary recommendation. The associations and BOALTC have 10 working days to respond indicating either concurrence with the preliminary recommendation or factual and documented disagreement along with an alternative preliminary recommendation. An opportunity to present such a statement to the Review Committee may also be requested. Payment policy statements and/or formula interpretations will be coordinated by one of the Section's Financial Supervisors and a Nursing Home Policy Staff person.

Policy statements will constitute a nursing home formula policy manual and copies of the manual or various policy statements will be available to the industry and consumer advocacy agencies following final approval by the BHCF Director or a designee.

Administrative review request form instructions and the Nursing Home Rate Administrative Review Request form are included in Appendices 11 and 12 of this handbook. Nursing homes must complete this form to qualify for review.

Provider Responsibilities

Specific responsibilities as Medicaid providers are stated in Section IV of Part A of the provider handbook. Reference Section IV for detailed information on fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

C. Recipient Information

Eligibility For Wisconsin Medicaid

Eligible recipients for Wisconsin Medicaid are issued identification cards. The identification cards include the recipient's name, date of birth, 10-digit identification number, medical status code, and an indicator of private health insurance coverage, managed care coverage, and Medicare coverage.

Medicaid identification cards are sent to recipients monthly. All identification cards are valid only through the end of the month in which they are issued. It is important that the provider or the designated agent check a recipient's identification card *prior* to providing service to determine recipient eligibility and limitations to the recipient's coverage.

If the recipient's identification card is held by the nursing home, it is the nursing home's responsibility to provide eligibility information to other providers of service.

B. Provider Information (continued)

Nursing Home Appeals Mechanism

A nursing home appeals mechanism exists under Section 49.45 (6m)(c) of the Wisconsin Statutes. Called the "Nursing Home Appeals Board," its purpose is to review applications from nursing homes for financial relief if demonstrated, substantial inequities exist in the individual nursing home Medicaid rates resulting from the annual nursing home payment formula. The Statute lists various criteria which may qualify a nursing home for appeals mechanism funding.

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For payment policy and/or formula interpretation development initiated by BHCF or by the Review Committee, a policy statement is drafted and reviewed by BHCF and then submitted to the nursing home associations and the Board on Aging and Long Term Care (BOALTC) for review and comment. The policy statement will include a preliminary recommendation. The associations and BOALTC have 10 working days to respond indicating either concurrence with the preliminary recommendation or factual and documented disagreement along with an alternative preliminary recommendation. An opportunity to present such a statement to the Review Committee may also be requested. Payment policy statements and/or formula interpretations will be coordinated by one of the Section's Financial Supervisors and a Nursing Home Policy Staff person.

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Medicaid identification cards are sent to recipients monthly. All identification cards are valid only through the end of the month in which they are issued. It is important that the provider or the designated agent check a recipient's identification card *prior* to providing service to determine recipient eligibility and limitations to the recipient's coverage.

If the recipient's identification card is held by the nursing home, it is the nursing home's responsibility to provide eligibility information to other providers of service.

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C. Recipient Information (continued)

Nursing home residents who have Wisconsin Medicaid are allowed to retain a small portion of any pension or other income they may have. These retained funds are known as the recipient's *personal needs allowance* and are used, with the recipient's permission, or the permission of the recipient's legal representative, to pay for items or services not generally covered by Wisconsin Medicaid or routinely provided through the nursing home daily rate. This allowance is for items or services not typically provided but available, such as items preferred by the resident rather than the brand item provided by the home and services (e.g., beauty salon permanents). The personal needs allowance is set by Wisconsin statute and is currently $40 per month.

Any income in excess of the personal needs allowance is used to cover the recipient's cost of care in the nursing facility. This amount is known as *resident liability*. The fiscal agent deducts the resident liability amount from amounts due to the provider as part of claims processing. If the liability amount is incorrect for any reason, the nursing home should notify the agency which certified the recipient for Wisconsin Medicaid eligibility.

Section V of Part A of the provider handbook has detailed information on eligibility for Wisconsin Medicaid, identification cards, temporary cards, restricted cards, and how to verify eligibility. Providers should review Section V of Part A of the provider handbook before services are rendered. A sample identification card is in Appendix 7 of Part A of the provider handbook.

Eligibility/Authorization Report

Nursing homes receive a monthly eligibility/authorization report on all of the nursing homes' recipients who have been eligible or authorized for services during the previous 60 days. The report is printed by the fiscal agent following the printing of the identification cards, and is generally sent to nursing homes during the first week of each month. The report's information is valid for the month in which the report is received or dated, *not* for the previous month (e.g., a report dated 07/31/95 contains eligibility information for July 1995).

In addition to current eligibility information, the report also includes level of care (LOC) authorization and recipient liability information. Carefully review this report to avoid claim denials and incorrect payments. An example of an Eligibility/Authorization Report form and the instructions are Appendices 13 and 14 of this handbook.

Care Level Determinations

Care level determinations for Medicaid recipients are made by the BQC. Care levels are determined at admission, when a resident becomes eligible for Medicaid benefits, and when the health care needs of the resident change. BQC reviews the recipient's care level annually.

Services are reimbursed when confirmation of care level determinations are received by the fiscal agent from the Division of Health, BQC. Medicaid care level codes are listed above under Nursing Home Reimbursement and in Appendix 15 of this handbook. If the nursing home bills before the care level is on file, the claim is denied. If the incorrect accommodation codes are used on the claim form, the claims will be denied pending proper care level verification through the Bureau of Quality Compliance.

BQC notifies the fiscal agent weekly to update the care level file. Nursing homes should contact the BQC if care level information is incorrect. Appendix 22 of this handbook contains the addresses of the BQC regional offices.

C. Recipient Information (continued)

Notice of Care Level Change

The Notice of Care Level Change is completed for Medicaid nursing home recipients whose care level is changed by the BQC staff. Nursing homes may request a care level review from the Division of Health regional office.

Nursing Home Discharges and Notification of Death

Providers must send notification of nursing home discharges and notifications of death to the recipient's certifying agency, such as the county which certified the recipient for Medicaid eligibility. The certifying agency is responsible for updating recipient information.

Nursing homes must notify the BQC regional office of all discharges and deaths of Wisconsin Medicaid recipients.

Notifications must include the:

- recipient name and Medicaid identification number;
- recipient date of birth;
- date of death or discharge; and
- nursing home's eight-digit Medicaid provider number.

Nursing homes must notify the BHCF within 30 days of a recipient's death if the DHSS' Estate Recovery Program applies (Refer to "Estate Recovery Program" in Section J of this handbook). When the Estate Recovery Program applies, the nursing home must send the "Estate Recovery Program Notification of Death" form in Appendix 28 of this handbook.

Documentation Requirements for ICF-MR or FDD Services

A physician must certify that ICF-MR services are needed. This certification is made at the time of admission, or if an individual applies for Wisconsin Medicaid while in a nursing home, before reimbursement can occur. Recertification by a physician must occur at periodic intervals after initial certification.

Individual Written Plan of Care - ICF-MR or FDD Services

Prior to initial admission to an ICF-MR, the attending physician must establish a written plan of care for each recipient. The plan of care must include:

- diagnoses;
- symptoms;
- complaints and complications indicating the need for admission;
- a description of the individual's functional level;
- objectives;
- any orders for medications;
- treatments;
- restorative and rehabilitative services;
- activities;
- social services and diet;
- plans for continuing care; and
- plans for discharge.

NOTE: The attending physician and other personnel involved in the recipient's care must review the plan of care at least every 60 days.

C. Recipient Information (continued)

Comprehensive Resident Assessment - NF and SNF

All nursing homes must enter a written comprehensive resident assessment in the recipient's record (according to HSS 132.60(8)(d), Wis. Admin. Code). Periodic reassessment is also required.

Any nursing facility that participates in the Medicaid or Medicare programs must use the resident assessment instrument specified by the state to assess all residents. Sections 1819 and 1919 of the Social Security Act specify assessment requirements for skilled nursing facilities for Medicare and nursing facilities for Medicaid, that provide nursing, medical, and rehabilitative care to Medicare and/or Medicaid beneficiaries. Section 49.498, Wis. Stats., includes the requirement for a resident assessment instrument.

These provisions require facilities to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity using a resident assessment instrument specified by the state. The resident assessment instrument consists of the minimum data set (MDS) and resident assessment protocols (RAPs). The MDS is a functionally based assessment tool; RAPs use MDS assessment information to identify potential problem areas for nursing home follow-up. RAPs also contain guidelines to help identify key causal or contributing factors to consider in developing, reviewing and revising a resident's care plan.

Appendices 23 and 24 of this handbook include the current, required MDS forms (effective January 1, 1996) for Medicaid nursing homes. More information, including a training manual and reference guide, for the resident assessment instrument is available from the BQC.

Nursing Home Pre-Admission Screening for Developmentally Disabled and Mentally Ill Recipients (PASARR)

The Omnibus Budget and Reconciliation Act of 1987 established resident review requirements for current and prospective nursing home residents. The requirements are called the Pre-Admission Screen/Annual Resident Review (PASARR). Wisconsin began implementation of the PASARR requirements on January 1, 1989. Nursing homes are notified of program changes through the DHSS' program memoranda.

PASARR - Purpose and Process

PASARR determines if a current or prospective resident is suspected of having a serious mental illness or a developmental disability and if the person is appropriate for nursing home placement. Nursing facilities may not admit individuals suspected of having a serious mental illness or a developmental disability until an assessment determines that the person needs nursing home placement and specialized services.

This process begins with a nursing home conducting a Level I screen prior to admission for any individual seeking admission. Appendix 25 of this handbook includes the Level I screening form. Based on the information collected from the Level I screen, an individual may also require a Level II screen. A Level II screen is required for all potential residents whose Level I screen indicates a possibility of major mental illness or a developmental disability. Level II screens must be conducted by the respective nursing facility's regional PASARR agency contracted by the Division of Community Services, Bureau of Community Mental Health.

C. Recipient Information (continued)

If a Level II screen is required, the Level I screener must notify their Regional PASARR Contractor. The contractor will perform the Level II screen and determine the appropriateness of nursing home placement and the need for specialized services. A person may not be admitted to a nursing home until the screening process is completed.

For further information on the Level II screening process, contact the DHSS Bureau of Developmental Disabilities at (608) 266-3717 or the Bureau of Community Mental Health at (608) 266-9316 or 266-7072.

Annual Resident Reviews (ARR)

Any resident with a serious mental illness or a developmental disability admitted to a nursing facility through the Pre-Admission Screening process must be re-screened on an annual basis. This is referred to as an Annual Resident Review (ARR). Annually is considered as occurring within every fourth quarter after the previous Level II screen or the previous ARR. The ARR can be performed only by the regional PASARR contractor.

PASARR Screening and Specialized Services Reimbursement

Nursing homes receive $30 for each Level I screen performed, regardless of the pay source of the recipient. Appendices 16 and 17 include the reimbursement request form and instructions.

Nursing homes are also eligible for a $9 per patient, per day supplement to the daily rate for individuals with a serious mental illness who have been determined by PASARR to require specialized services. This does not include private pay residents. The reimbursement supplement is only for days in which the resident is in the facility and receiving specialized services, excluding therapeutic and hospital bed-hold days. There is no supplement to the daily rate for the developmentally disabled residents due to other funding sources for specialized services, including the Medicaid nursing home formula.

Requirements for Specialized Services Reimbursement

To be eligible for specialized services reimbursement, the nursing facility must have a resident(s) determined by a Level II Pre-Admission Screen or by an ARR to need facility placement and require specialized services. The facility must submit an Individualized Specialized Services Plan of Care to BHCF, Nursing Home Section. The nursing facility must submit a specialized services roster claim form monthly to the BHCF's Nursing Home Section. Appendix 26 of this handbook includes the specialized services roster claim form. Payments are made quarterly and are reflected on the nursing home's Remittance and Status Report by the Medicaid fiscal agent.

Nursing facilities must complete residents' ARRs within the calendar quarter in which they are due. Reimbursement will be withheld if the ARRs are past due. Reimbursement will be reinstated when the ARRs are completed and the specialized services determination date is updated on the roster claim form.

For further information on reimbursement, please contact the BHCF Nursing Home Section Analysis Unit.

C. Recipient Information (continued)

Managed Care Program Coverage

Wisconsin Medicaid managed care programs are developed principally for the Aid for Families with Dependent Children (AFDC) and Healthy Start population. There are a few pilot managed care projects for the elderly and disabled population. The emphasis is prevention, primary, and acute care services. Nursing home services may be included in the plan. Providers should be aware of managed care as an initiative of Wisconsin Medicaid, and should be aware that Medicaid recipients may be enrolled in contracted managed care programs. Managed care plans may include nursing home services subject to the conditions and terms of the individual plans themselves.

Medicaid recipients enrolled in Medicaid-contracted managed care programs receive a yellow Medicaid identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, 22, 22a, and 22b of Part A of the provider handbook.

Providers must always check the recipient's current Medicaid identification card for managed care program coverage before providing services. Claims submitted to the fiscal agent for services covered by Medicaid-contracted managed care programs are denied.

For recipients enrolled in a Medicaid-contracted managed care program, all conditions of reimbursement and prior authorization for nursing home services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, and hospitalizations is included in Section IX of Part A of the provider handbook.

Estate Recovery Program

According to s.49.496, Wis.Stats., the DHSS administers an estate recovery program as part of the Medicaid Program. The BHCF is the administering entity. The Wisconsin Estate Recovery Program (ERP) entails Medicaid collecting funds from the estate of a deceased Medicaid-nursing home recipient under certain conditions. The DHSS may recover funds from the estate of a deceased recipient if:

- the recipient has no surviving spouse; and
- no minor or disabled child.

The nursing home must notify the DHSS within 30 days of a resident's death if the above conditions apply by completing the "Estate Recovery Program Notification of Death" form. Refer to Appendix 28 of this handbook for a copy of this form.

If the DHSS is initiating an estate recovery action, the BHCF sends the nursing home an affidavit 20 days after the date of death. The affidavit claims the funds and advises the nursing home to transmit the funds to the DHSS. Refer to Appendix 27 of this handbook for a copy of the affidavit.

For additional information on the Estate Recovery Program, please contact the Coordination of Benefits Unit of the BHCF.

A. General Information

Covered nursing home services are medically necessary services provided by a certified nursing home to a nursing home recipient and prescribed by a physician in a plan of care.

Medicaid-certified nursing homes are called nursing facilities (NFs). Nursing homes which also participate in Medicare are called skilled nursing facilities (SNFs). Certified facilities, including distinct parts, which predominantly serve the developmentally disabled are called intermediate care facilities for the mentally retarded (ICF-MRs) or facilities for the developmentally disabled (FDDs).

Facilities that meet the federal definition of institutions that primarily accept and treat persons with mental illness are called institutions for mental diseases (IMDs). All facilities that meet the definition of an IMD are notified by the Department of Health and Social Services (DHSS). Wisconsin Medicaid does not cover any services provided to residents of an IMD who are between the ages of 21 and 64. This means that residents of an IMD between 21 and 64 are not eligible for Medicaid services, including all separately billable Medicaid services.

B. Services Reimbursed in the Nursing Home Daily Rate

For NFs and FDDs, Medicaid nursing home payment policies and principles are used and are contained in the annual nursing home payment formula or *Methods of Implementation*. The payment formula is an annual formula corresponding to the State Fiscal Year (July-June); and formula updates and modifications are generally effective each July 1.

The setting of rates for each certified nursing home is the responsibility of Medicaid Regional Auditors. This includes setting interim rates (if applicable), rates for new operations, facility phase down rates, and final rates. Information on the formula with respect to individual nursing homes can be obtained by contacting the home's regional auditor. Appendix 21 of this handbook contains the addresses of Medicaid Regional Auditors.

The payment formula must comply with federal law and regulations which state that Medicaid payments to nursing facilities "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable laws, regulations, and quality and safety standards..." (SSA 1902 (a)(13)(A)). The law further requires that the State (Medicaid) Agency "take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident...) of complying with (standards)" (SSA 1902 (a) (13) (A)).

Using this norm, the costs incurred by efficiently and economically-operated facilities for all routine, day-to-day health care services and materials provided to recipients by a nursing home are reimbursed in the daily rate. Every certified nursing facility has daily rates calculated for each accommodation code or care level served in the facility with the rate based upon a payment formula. Please refer to the annual Methods for further information and specifics on the formula.

According to HSS 107.09, Wis. Admin. Code, routine services and costs include:

1. nursing services;
2. special care services, including activities, therapies, recreation, social services, and religious services;

B. Services Reimbursed in the Nursing Home Daily Rate (continued)

3. supportive services, including dietary, housekeeping, maintenance, institutional and personal laundry services, but excluding personal dry cleaning services;
4. administrative and other indirect services;
5. physical plant, including depreciation, insurance, and interest on plant;
6. property taxes;
7. over-the-counter (OTC) analgesics and medically necessary non-covered OTC drugs;
8. non-medical transportation services (medical transportation is separately reimbursable; see the annual Methods for specific information);
9. services for developmentally disabled residents; and
10. supplies and equipment. This includes dietary supplies, incontinence supplies, personal comfort supplies, medical supplies and equipment, and other similar items. All of these items are associated with a recipient's personal living needs in normal and routine nursing home operations. Section 5.000 of the annual Methods of Implementation contains a list of these items.

Certain durable medical equipment (DME) and disposable medical supplies (DMS) are separately reimbursable for nursing home recipients. Please refer to the section below on DME/DMS, the DME (Part N) provider handbook, along with the DMS Index and DME Index for further information and specifics on DME and DMS. The DME (Part N) provider handbook and the Indices applies to all Medicaid recipients, including all Title XIX nursing home residents. The DME Index and DMS Index identify DME and DMS items included or excluded in the nursing home daily payment rate.

C. Ancillary Add-ons to the Nursing Home Daily Rate

Certain services that are normally billed separately from the nursing home daily rate may be included as an ancillary add-on to the nursing home daily rate. An add-on is for specifically-identified covered services and materials which could be billed separately to Wisconsin Medicaid by an independent provider of service. These services and materials must be available to all Medicaid recipients of the facility. If some portion of the services and materials must be supplied by an outside provider, the facility is responsible for payment to the outside provider.

Nursing homes need prior approval from Medicaid regional auditors for ancillary add-ons.

Nursing homes who request ancillary add-ons must be able to document that these services will cost no more than if they are billed separately, according to HSS 107.09(4)(j), Wis. Admin. Code. Nursing homes interested in ancillary add-ons should contact their Medicaid regional auditor.

D. Ancillary Services Reimbursable Beyond the Nursing Home Daily Rate

Ancillary services for nursing home residents are those which are considered non-routine and, thereby, not included in the nursing home daily rate. Certain covered ancillary services are separately reimbursable from the nursing home daily rate. The costs incurred for ancillary services are billed through ancillary codes.

Wisconsin Medicaid requires prior approval for ancillary services except medical transportation.

D. Ancillary Services Reimbursable Beyond the Nursing Home Daily Rate (continued)

For lab services (code "N3" below) and radiology/x-ray (code "N4" below), prior approval is required from the BHCF Nursing Home Section Regional Auditors. For the ventilator care, AIDS care and private room requests (codes "N6," "N7," and "N9" below), prior authorization is required from the BHCF Medicaid Audit Section.

Nursing home providers do not need separate Medicaid certification to provide ancillary services. In some cases, nursing homes may need to perform additional services to qualify for Medicaid ancillary coverage.

The valid ancillary services and their corresponding codes are:

N2 Transportation: This is medical transportation of a recipient to obtain health treatment or care. The treatment or care must be prescribed by a physician as medically necessary and must be performed at a physician's office, clinic, or other recognized medical treatment center. The nursing home must provide the transportation in its controlled equipment and by its staff, or by common carrier (e.g., bus, taxi). The charges are cost per mile, not staff cost. Billings may not exceed the nursing home's actual cost. Routine transportation to activities, such as social events, is part of the daily rate. For specialized motor vehicle transportation, please see *Wisconsin Medicaid Updates* on specialized motor vehicle transportation services.

N3 Laboratory Services.

N4 Radiology Services.

N6 Private Room: A private room may be prior authorized under certain medically necessary conditions for isolation per HSS 132 and Centers for Disease Control guidelines. Please contact the BHCF Medicaid Audit Section for more information on qualifying conditions. An approved private room rate is the facility's Wisconsin Medicaid rate plus the difference between the facility's daily private-pay semi-private room rate and private-pay private room rate up to $35. Documentation of the rate differential must accompany the prior authorization request.

N7 Ventilator Care: Wisconsin Medicaid provides additional reimbursement for ventilator dependent recipients admitted to nursing homes authorized to provide ventilator dependent care. The current ventilator rate is listed in the Nursing Home Methods of Implementation in Section 4.690.

N9 AIDS Care: A provider accepting recipients with a diagnosis of AIDS may receive additional reimbursement for the recipient. The current AIDS rate is listed in the Nursing Home Methods of Implementation in Section 4.690.

E. Other Ancillaries

Other Ancillaries

Nursing facilities may bill other ancillary services that do not have "N" codes, subject to BHCF approval. For example, certain supplies and equipment for tracheostomy care and exceptional supply needs for ventilator-dependent patients and patients receiving similar care. Other supplies and equipment may be reimbursable to a nursing facility separate from the daily rate without prior authorization and billed on the HCFA 1500 claim form. Supplies and equipment listed in Sections 5.310 and 5.160 may be reimbursed separate from the daily rate subject to prior authorization. Supplies listed in Sections 5.110-5.150 are included in the daily rate. For identification of specific items of equipment and supplies to determine whether the items are in the daily rate or separately billable, please refer to the DME Index and DMS Index. Please see Sections II-I and II-J, along with Section III on prior authorization for additional information.

F. Nursing Home Head Injury Patients

Nursing Home Head Injury Patients

According to Section 4.692 of the Nursing Home Methods, approved facilities providing specialized treatment for head injuries may receive a negotiated rate, in lieu of the facility's daily rate, for each resident participating in the head injury program. Allowable cost principles and formula maximums may be applied to rate calculations. Rates are all-inclusive, including all durable medical supplies and exceptional supplies. Rates further include bedhold. Rates may be updated periodically to account for changes in facility costs. The treatment program must be approved by the Department of Health and Social Services (DHSS) based on established criteria for admission, continuing stay, discharge and other program requirements as determined by the DHSS.

Treatment program and rates must be appropriate and receive prior approval of the BHCF Medicaid Audit Section and Nursing Home Section. Effective July 1, 1994, the billing for such treatment was converted from an ancillary billing to an accommodation code. Refer to Section I-B of this handbook for a listing of accommodation codes.

Facilities interested in the program requirements and information for treatment of head injured persons should contact:

Director
Bureau of Health Care Financing
P.O. Box 309
Madison WI 53701-0309

G. Services Provided by Other Providers

Generally, when a billable, covered service is provided to a Medicaid nursing home resident by an independent provider of service (e.g., dentist outside of the nursing home), reimbursement may be claimed only by the independent provider under the independent provider's number. Medicaid certification and program requirements for that provider type apply.

H. Bedhold

General Information

Bedhold is covered for therapeutic leaves of any length and for hospital stays up to 15 days. Payment will only be made if the nursing home meets the requirements of the qualifying criteria. Specific bedhold requirements are communicated in BQC program memoranda. The nursing home must have an occupancy threshold of 95 percent for the previous month or have had eight vacant beds or less in the previous month to qualify for Medicaid bedhold coverage. Accommodation codes for billing hospital bedhold charges or therapeutic leaves are in Appendix 15 of this handbook.

Bedhold Days for Hospital Visits

Hospitalization bedhold days are reimbursable for up to 15 days per hospital stay. There is no limit on the number of stays per year. Beyond 15 days, hospital bedhold is a noncovered service.

1. The first day that the recipient leaves the nursing home, regardless of the time of day, is the first day the recipient is considered absent. The day the recipient returns to the nursing home does not count as a bedhold day, regardless of the time of day.
2. All hospital bedhold days up to 15 days are considered covered services; therefore, bedhold charges to the recipient, family, or friends are prohibited. No resident or third party may be charged for covered, bedhold days for a Wisconsin Medicaid recipient. With the prior consent of the recipient or a legal representative, bedhold may be charged to hold the bed after 15 days of Medicaid-covered hospital, bedhold services.

H. Bedhold (continued)

3. Recipients cannot be administratively discharged from the nursing home unless they remain in the hospital longer than 15 days and no agreements have been made to hold the bed through payments by the resident, family or guardian and the resident and legal representative or family have been given a 30 day notice of involuntary discharge through the federal requirements for discharge under 42 CFR 483.12.
4. Claims for bedhold days during leaves for hospitalization cannot be submitted when it is known in advance that a recipient will not return to the nursing home following the hospital stay.

Providers can claim only the days prior to:

- the recipient's return to the nursing home;
- the recipient's death in the hospital;
- notification of the recipient's terminal condition; or
- the recipient's need for discharge to another facility.

Bedhold Days for Therapeutic Visits

Therapeutic visits are overnight visits (one or more nights) by a recipient with relatives or friends. Bedhold days for therapeutic visits are reimbursable if the recipient requests leave days for visits, and if the recipient's physician approves the leave in the physician's plan of care for the recipient. This statement must include the rationale for and the anticipated goals of the leave, as well as any limitations on the frequency or duration of leaves. The provider must note any time there is a change in the recipient's condition in the plan of care. The following information also applies to bedhold days for therapeutic visits:

1. The first day that the recipient leaves the nursing home, regardless of the time of day, is the first day the recipient is considered absent. The day the recipient returns to the nursing home does not count as a bedhold day, regardless of the time of day.
2. All therapeutic leaves of absence for visits are considered covered services until determined otherwise. Bedhold charges to the recipient, family, or friends are prohibited.
3. Bedhold days for a therapeutic visit leave, when it is known in advance that a recipient does not plan to return to the facility following the therapeutic visit, are not covered under Wisconsin Medicaid.
4. A staff member designated by the administrator (e.g., social service director or nursing service director) must document the recipient's absence in the recipient's records and approve each individual leave based upon physician order(s).

Bedhold Days for Therapeutic/Rehabilitative Programs

Bedhold days for therapeutic or rehabilitative programs are covered when:

1. The therapeutic/rehabilitative program, in the opinion of the recipient's physician, contributes to the recipient's mental, physical, or social development according to the recipient's plan of care. The program must meet the definition of a therapeutic or rehabilitative program:

H. Bedhold (continued)

"A formal or structured medical or health care activity which is designed to contribute to the mental, physical or social development of its participants, and is certified or approved, or its sponsoring group is certified or approved, by a national standard-setting or certifying organization when such an organization exists." (HSS 101.03[165], Wis. Admin. Code)

2. Upon request from Wisconsin Medicaid, the nursing home must submit in writing the following information regarding the recipient:
   - dates of the program's operation;
   - number of participants;
   - identification of the program's sponsorship;
   - anticipated program goals and how the goals will be accomplished (treatment modalities); and
   - the program's leadership or faculty and their credentials.
3. Each time the recipient attends a therapeutic or rehabilitative program, the recipient's physician must include:
   - a written statement in the plan of care approving for the recipient's participation in the program;
   - the goals of the program which apply to the recipient; and
   - the duration or frequency of the recipient's participation.
4. The first day that the recipient leaves the nursing home, regardless of the time of day, is the first day the recipient is considered absent. The day the recipient returns to the nursing home does not count as a bedhold day, regardless of the time of day.
5. Leaves of absence to attend therapeutic or rehabilitative programs are considered covered services until determined otherwise. Bedhold charges to the recipient, family, or friends are prohibited.
6. A staff member designated by the administrator (e.g., director of nursing service or social service director) must document the recipient's absence in the recipient's chart.
7. The bedhold for therapeutic/rehabilitation programs cannot be claimed if the recipient is receiving these services at another in-state or out-of-state nursing home.
8. There is no limitation on bedhold days for therapeutic/rehabilitation leave as long as all other criteria are met.

For additional information on bedhold policies, such as resident transfer and discharge rights requirements and Medicare Part A implications for bedhold, please refer to the BQC Memoranda on this subject. Copies of BQC Memos can be obtained directly from the BQC.

I. DME and Wheelchairs Provided to Nursing Home Recipients

General Information

DME and wheelchairs reasonably associated with a patient's personal living needs in normal and routine nursing home operations are to be provided to Wisconsin Medicaid recipients without charge to the recipient, the recipient's family, or other interested persons. The cost of all wheelchairs, including geriatric chairs but excluding motorized wheelchairs or vehicles, is included in the nursing home payment rate. All items must be suitable for use in the recipient's place of residence.

I. DME and Wheelchairs Provided to Nursing Home Recipients (continued)

Most DME is reimbursed through the nursing home daily rate. Certain DME is separately reimbursable for nursing home recipients. Some DME requires prior authorization, and some DME can be billed separately from the daily rate without prior authorization.

Wheelchairs Reimbursable Through the Nursing Home Daily Rate

All manual wheelchairs without a custom adaptive positioning system are reimbursable through the nursing home daily rate.

Wheelchairs Separately Reimbursable and Not Included in the Nursing Home Daily Rate

Under certain conditions, manual wheelchairs with a custom adaptive positioning system, and all power/motorized wheelchairs are not included in the nursing home daily rate. Also repairs of a resident-owned power wheelchair or a wheelchair with a custom adaptive positioning system are reimbursed separately by Wisconsin Medicaid. Repairs over $150 require prior authorization. This topic is addressed in more detail in Sections II-D, II-J, and III-H of the Part N DME Handbook and its updates.

DME and Wheelchairs

Under certain conditions, DME and wheelchairs may be billed separate from the nursing facility payment rate with prior authorization. Nursing homes can bill directly or use a certified DME provider to bill certain DME. Please see Section II-J of the DME (Part N) provider handbook for information on this topic and the DME Index for identification of which DME items are in the rate and which can be billed separately. *Wisconsin Medicaid Updates* on DME and wheelchairs provide current information on this topic.

Separate payment for certain DME may be allowed if the DME is personalized or custom-made for a recipient resident and is used by the resident on an individual basis for hygienic or other reasons. Some of these items require prior authorization and some do not. These items include, but are not limited to, orthoses (see Part N, Section II-F), prostheses (including hearing aids) (see Part N, Section II-H and the Wisconsin Medicaid audiology handbook), orthopedic or corrective shoes (see Part N, Section II-G), and pressure relief beds (see Part N, Section III-B). Please see Sections II and III of the DME (Part N) provider handbook and the DME Index for covered services and prior authorization policies for DME for nursing home residents.

According to HSS 107.09(4), Wis. Admin. Code, the following items are not included in calculating the daily nursing home rate but may be reimbursed separately: oxygen in liters, tanks, or hours, including tank rentals and monthly rental fees for concentrators (see Part N, Sections II-J and III-B); and tracheostomy and ventilatory supplies and related equipment, subject to guidelines and limitations published by the DHSS. The guidelines and limitations are contained in the DME (Part N) provider handbook, Section II-J, *Wisconsin Medicaid Updates*, and the DME Index.

DME and DMS exceptions to the daily rate (e.g. oxygen and supporting respiratory equipment), are billed on the HCFA 1500 claim form. Please see Section IV of this handbook for information on claims submission.

Medicaid; Nursing Homes; Specialized Services; MI; MR

The First Circuit held that the Nursing Home Reform Amendments (NHRA) to the Medicaid law require states to provide specialized services to persons found to require both nursing facility care and specialized services for mental illness or mental retardation. *Rolland v. Romney, 318 F.3d 42 (1st Cir. 2003).*

A class of nursing home residents in Massachusetts, who have mental retardation, entered into a settlement agreement with the state, which obligated the state to provide specialized services under the NHRA. A year later, the district court found that the state was not in compliance with the settlement agreement and ordered it to provide specialized services for all class members needing them. The state appealed, arguing that the NHRA requires it to provide specialized services only to those individuals who are found not to require nursing home care.

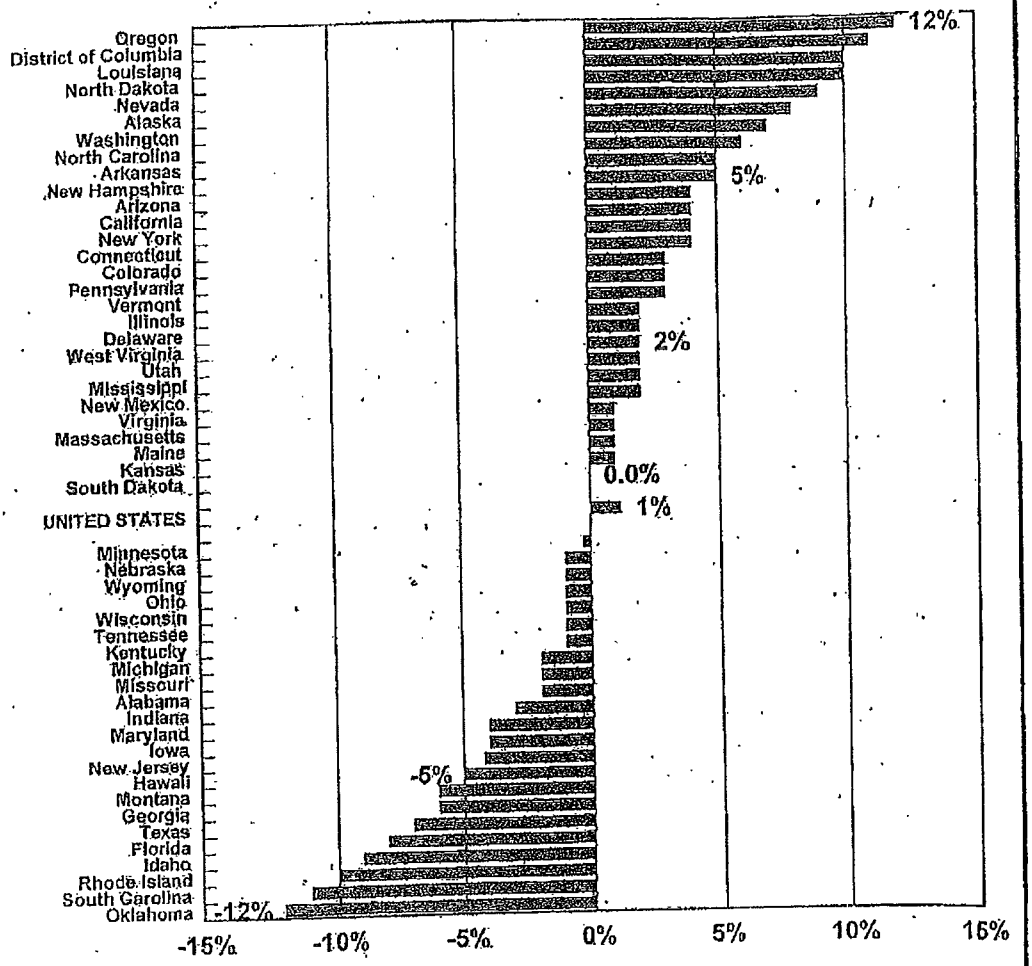
The First Circuit affirmed. Based on the statutory language and legislative history, as well as agency interpretations, the court held that Massachusetts is required to provide dual need residents (i.e., those who need both nursing facility care and specialized services) with specialized services if screening deems them necessary. The NHRA is silent on the issue of whether states must provide specialized services to dual need residents. However, the statutory language contains clues as to Congress' intent. First, the NHRA explicitly requires states to provide specialized services to residents who need them but who do not require nursing facility care. This language appears designed to ensure that those most likely to be left out—those not in a facility—receive specialized services if needed.

Second, the preadmission screening and annual resident review process (PASARR) requires a determination of whether nursing facility care is required and whether specialized services are required. The state's construction of the statute would render the second prong of the PASARR screening requirements for specialized services a meaningless exercise for individuals found to need nursing facility care in the first prong because the state would not be required to provide them.

Third, the statute requires states to create an appeals process for individuals adversely impacted by the outcome of any PASARR screening determination. *See* 42 U.S.C. §1396r(e)(7)(F). This language suggests that Congress intended the determination of need for specialized services to result in the provision or denial of those services for every individual screened.

Finally, the Secretary of the U.S. Department of Health and Human Services has promulgated a rule explicitly requiring states to provide specialized services to dual need residents. *See* 42 C.F.R. §483.116(b). The court rejected the state's argument that the regulation exceeds the bounds of the statute and "runs directly counter to one of the primary purposes of the Act, namely, the conservation of federal and state funds." Although Congress was concerned with fiscal conservatism, the statue's primary purpose was to ensure that the needs of nursing facility residents with mental retardation are identified and serviced. *See* H.R. Rep. No. 100-391, pt. 1, at 459, reprinted in 1987 U.S.C.C.A.N. at 2313-279. The regulation is consistent with this goal and, as such, is not contrary to the statute. It follows that it is endowed with controlling authority. *See Chevron U.S.A. Inc. v. Natural Res. Def. Council*, 467 U.S. 837 (1984).

Figure 5a
23 States Reduced Total Inflation-Adjusted I/DD Spending During 2008-09



Source: Braddock et al., Coleman Institute and Department of Psychiatry, University of Colorado (2011).

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South Carolina
Health & Human Services

SOUTH CAROLINA HEALTHY CONNECTIONS (MEDICAID) PROVIDER MANUAL

NURSING FACILITY SERVICES

November 1, 2005 Edition
Updated January 1, 2012

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
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MEDICAID BULLETIN

NF-GEN 05-05
NF-ICF/MR 05-02
NF-IMD 05-02
NF-SB 05-02

TO: Nursing Facility Providers

SUBJECT: Medicaid Policy Manual for Nursing Facility Services Providers

The enclosed revised Medicaid Nursing Facility Services Provider Manual is effective November 1, 2005 and includes all previous HIPAA changes and Medicaid policy bulletins.

This manual is to be used for program information and requirements, billing procedures, and provider services guidelines. Due to several substantial changes in policy, providers are urged to carefully review this revision.

In addition to inclusion of policy changes specific to the Nursing Facility Services program area, the new provider manuals for all Medicaid programs have been reformatted to give them a more consistent, standardized layout and to improve navigation and readability. Headings for each subsection appear on the left side of the page, with the corresponding information on the right. "Chapters" are now called "Sections," and the numbering system has been simplified.

The revised manual is organized generally as follows, with each section having its own table of contents:

Section 1, General Information and Administration, contains an overview of the South Carolina Medicaid program, as well as information about record retention, documentation requirements, utilization review, program integrity, and other general Medicaid policies.

Section 2, Policies and Procedures, describes policies and procedures specific to the Nursing Facility Services program.

Section 3, Billing Procedures, contains billing information that is specific to the South Carolina Medicaid Nursing Facility Services program, as well as program-specific guidelines for claim filing and processing.

Section 4, Resident Rights, contains the federal regulations pertaining to resident rights that are specific to the Medicaid Nursing Facility Services program.

Enrollment (Cont'd.)

Not reporting this change of information promptly could result in a delay of payment to the provider. Contact information for these areas is listed below:

Contracted Providers	Non-Contracted Providers
Division of Contracts	Medicaid Provider Enrollment
SCDHHS	Post Office Box 8809
Post Office Box 8206	Columbia, SC 29202-8809
Columbia, SC 29202-8206	1-888-289-0709
(803) 898-2605	Fax: (803) 699-8637

The Medicaid program administered by SCDEHHS is considered to be a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Extent of Provider Participation

Providers have the right to limit the number of Medicaid patients they are willing to treat within their practice; however, providers may not discriminate in selecting the Medicaid beneficiaries they will treat or services they will render. A provider may not refuse to furnish services covered under Medicaid to an eligible individual because of a third party's potential liability for the service(s). A provider who is not a part of a Managed Care Organization's network may refuse service to a Medicaid MCO member.

A provider and a beneficiary (or the beneficiary's guardian or representative) should determine before treatment is rendered whether the provider is willing to accept the beneficiary as a Medicaid patient. In an emergency, or if a provider cannot determine that a patient is Medicaid-eligible at the time service is rendered, the provider should meet with the beneficiary (or the beneficiary's legal guardian or representative) at the earliest possible date to determine whether the provider is willing to accept the beneficiary as a Medicaid patient for the previously rendered service. To avoid disputes or misunderstandings, providers are encouraged to document the details of their provider-patient agreement in the patient's record.

In furnishing care to beneficiaries who are participating in a Medicaid managed care option, all providers are required to comply with the benefit requirements specified by the applicable managed care program with respect to issues such as the extent of approvals for referrals, etc. Specific

Extent of Provider Participation (Cont'd.)

questions may be addressed directly to the managed care provider or the Division of Care Management at (803) 898-4614.

Once a provider has accepted a beneficiary as a Medicaid patient, it is the responsibility of the provider to deliver all Medicaid-covered services throughout the course of treatment. The policy section of this manual may include clarification of specific program policies.

Non-Discrimination

All Medicaid providers are required to comply with the following laws and regulations:

- Title VI of the Civil Rights Act of 1964 that prohibits any discrimination due to race, color, or national origin (45 CFR Part 80)
- Title V, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 that prohibits discrimination on the basis of handicap (45 CFR Part 84)
- The Americans with Disabilities Act of 1990 that prohibits discrimination on the basis of disability (28 CFR Parts 35 & 36)
- The Age Discrimination Act of 1975 that prohibits discrimination on the basis of age (45 CFR Parts 90 and 91)

Service Delivery

Freedom of Choice

Except as otherwise specified in this manual, a Medicaid beneficiary has the right to choose any provider who is both a participant in the Medicaid program and willing to accept the beneficiary as a patient.

However, once a beneficiary exercises his or her freedom of choice by enrolling in a Medicaid managed care option, the beneficiary is required to follow that plan's requirements (e.g., use of designated primary and specialist providers, precertification of services, etc.) for the time period during which the beneficiary is enrolled in the managed care option.

Medical Necessity

Medicaid will pay for a service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service (the provision of which may be limited by specific manual

Medical Necessity (Cont'd.)

provisions, bulletins, and other directives) is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records or other appropriate documentation for each beneficiary must substantiate the need for services, must include all findings and information supporting medical necessity and justification for services, and must detail all treatment provided. Medicaid will not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.

RECORDS/ DOCUMENTATION REQUIREMENTS

GENERAL INFORMATION

As a condition of participation in the Medicaid program, providers are required to maintain and provide access to records. These records should fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries. Unless program policy otherwise allows, this documentation must be present in the beneficiaries' records before the provider files claims for reimbursement. For the purpose of reviewing and reproducing documents, providers shall grant to staff of SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the Government Accountability Office (GAO), and the U.S. Department of Health and Human Services (USDHHS) and/or any of their designees access to all records concerning Medicaid services and payment. These records may be reviewed during normal business hours, with or without notice.

A provider record or any part thereof will be considered illegible if at least three medical or other professional staff members who regularly perform post-payment reviews are unable to read the records or determine the extent of services provided. If this situation should occur, a written request for a translation may be made. In the event of a negative response or no response, the reimbursed amount will be subject to recoupment.

Assuming that the information is in a reasonably accessible format, the South Carolina Medicaid Program will accept records and clinical service notes in accordance with the Uniform Electronic Transactions Act (S.C. Code Ann. §26-6-10 *et seq.*). Reviewers and auditors will accept electronic documentation as long as they can access them and the integrity of the document is ensured. Furthermore, providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

The minimum retention period for Medicaid records is five years. Exceptions include providers of hospital and nursing home services, who are required to maintain records

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SECTION 2: POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Long-Term Care Assessment — DHHS Form 1718 (Cont'd.)

- When a resident is located in the community at the time of application, CLTC or the staff of the agency actively involved with the resident may complete the assessment.

The assessment form must be completed accurately, obtaining all available information. The assessor should read the South Carolina Assessment and Level of Care Manual for Medicaid-Sponsored Long-Term Care Services thoroughly before completing an assessment.

The assessment must be completed by a registered nurse, social worker, social services worker, and/or physician. A person who is related to the resident may not complete any portion of the assessment.

The CLTC nurse consultant has 14 calendar days from receipt of the referral to complete the assessment and determine the level of care.

Level of Care Certification Letter — DHHS Form 185

Prior to determining a level of care, the CLTC nurse consultant is required to make a visit to see the resident prior to determining the level of care. After making the level-of-care determination, the CLTC nurse consultant sends a Level of Care Certification Letter (DHHS Form 185) to all involved parties. The effective date on the Level of Care Certification Letter corresponds to the date requested by the nursing facility or SCDHHS. If a date is not requested, certification is issued based on the date the level of care is determined. Retroactive level-of-care certification will not be routinely authorized for more than 10 days prior to the date of the receipt of the Long-Term Care Assessment form (DHHS Form 1718) by the CLTC area office.

Appeals

A resident may appeal the level-of-care decision made by CLTC. The resident (or designated representative) must write a letter requesting an appeal within 30 days of the date of the official written notification issued by CLTC. The letter must be addressed to:

Division of Appeals and Hearings
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

SECTION 2: POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Appeals (Cont'd.)

This information is printed on the back of the written notification (DHHS Form 185) sent to the resident.

Note: Failure to adhere to the guidelines above may result in a denial of Medicaid certification. Also, the 30 administrative days for alternate placement provision do not apply to CLTC adverse decisions prior to the start of Medicaid provider payment.

Preadmission Screening and Resident Review (PASARR)

The Omnibus Budget Reconciliation Act (OBRA) of 1987 provides for Preadmission Screening and Resident Review (PASARR) requirements to screen residents prior to a nursing facility placement. Residents identified at the Level I screening process with a serious mental illness (MI) or mental retardation (MR) are then referred through the Level II review process to determine the need for services of a lesser intensity or specialized rehabilitation services. A Medicaid-certified nursing facility is prohibited from admitting any new resident who has a serious mental illness or mental retardation unless it has been determined that the resident requires the level of services provided by the nursing facility and the resident is in need of specialized services or specialized rehabilitation services for mental illness or mental retardation.

Level I Screening — DHHS Form 234

Nursing facility and/or hospital staff may conduct the PASARR Level I screening, provided that the individual conducting the screening has been trained by the local CLTC office and a Memorandum of Agreement between the nursing facility or the hospital and CLTC has been signed. The screenings must be complete and accurately reflect the resident's condition at the time of the screening. DHHS Form 234 is used to record the results of the screening. (Refer to the Forms section for an example of DHHS Form 234.) Level I screening must also be conducted when:

- A resident is admitted to a Medicaid-certified nursing facility.
- A resident has exceeded the 10-day bed hold prior to a nursing facility readmission from a hospital for inpatient treatment of a psychiatric condition.
- A resident transfers from another state to South Carolina.

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SECTION 2: POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Level I Screening — DHHS Form 234 (Cont'd.)

- A resident is admitted for respite to a nursing facility. (A respite care stay is defined as 14 days or less.)

Level I screening is not necessary when:

- A resident transfers from one certified nursing facility to another certified nursing facility within South Carolina. The transferring facility is responsible for sending all PASARR information to the receiving facility.
- A resident is admitted to a facility that is not Medicaid certified.
- There are intra-facility conversions from one payment source to another.
- A resident is admitted to a nursing facility from a hospital for an acute inpatient treatment of the same condition for which he or she was hospitalized and where the nursing facility stay is anticipated to be less than 30 days, as certified by a physician. If a resident who enters a nursing facility as an exempted hospital discharge is later found to require more than 30 days of nursing facility care, the DMH or the DDSN must conduct the PASARR Level I within 40 calendar days of admission.
- The admissions are swing-bed or administrative days admissions.

Nurses or social workers (to include social work designees or social services workers) within the facility may conduct Level I screening.

Without exception, a Medicaid nursing facility must comply with preadmission screening mandates of PASARR, regardless of payment source.

Level II Determination — DHHS Form 250

CLTC is responsible for Level II referrals on residents entering a nursing facility. The nursing facility is responsible for Level II referrals due to significant changes in a resident's condition within its facility. Residents identified through the Level I process as having an MI or MR are referred through the Level II process to determine the need for services of a lesser intensity (to be provided by the nursing facility) or specialized services (to be provided

SECTION 2: POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Level II Determination — DHHS Form 250 (Cont'd.)

by the DMH or DDSN, as appropriate). The nursing facility is responsible for notifying and explaining the Level II determinations and advising the resident and responsible party regarding their right to appeal the outcome of any part of the PASARR process. DHHS Form 250 is used to record the results of the review. (Refer to the Forms section for an example of DHHS Form 250.)

Once a resident who has been determined to need treatment for a mental illness or mental retardation through the Level II process has been admitted to a nursing facility, an additional Level II PASARR referral will be required when there is a significant change in a resident's condition. A significant change is defined as a major change in a resident's status that is not self-limiting, impacts more than one area of a resident's health status, and requires interdisciplinary review or revision of the plan of care.

The following items should be included in the Level II packet:

- Level I Screening (DHHS Form 234)
- Mini Mental State Exam
- Psychiatric Evaluation (DHHS Form 250) only for a resident with mental illness
- Consent Form (DHHS Form 121)
- South Carolina Long-Term Care Assessment (DHHS Form 1718)
- Social History (DHHS Form 247 for residents with MI or DHHS Form 248 for residents with MR)
- Resident's history and physical completed by the physician
- Copies of the resident's hospital and/or nursing home records

Refer to the Forms section for examples of the Mini Mental State Exam, DHHS Form 121, DHHS Form 247, and DHHS Form 248.

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Delegated Status Facilities — Certification

The Department of Mental Health (DMH) has the authority for preadmission review of residents 65 years of age and older admitted to the IMD. Each Medicaid-sponsored resident must be issued a certification by the DMH indicating the level of care and effective date. This certification must be signed by a physician.

The Department of Disabilities and Special Needs (DDSN) has the authority for preadmission review of residents admitted to an ICF/MR. Each Medicaid-sponsored resident must be issued a certification by DDSN indicating the level of care and the effective date. This certification must be signed by a nurse, social worker, and/or physician.

SCDHHS has review and oversight for all admissions to DMH and DDSN facilities. SCDHHS determinations will prevail in all disputed cases.

DMH Responsibilities

DMH retains the function of determining the need for nursing facility care for residents residing within DMH facilities. However, an independent contractor may conduct psychiatric evaluations on residents residing in the DMH facility who meet the criteria established for having a mental illness.

DDSN Responsibilities

DDSN retains the function of conducting evaluation and determination of residents applying to or residing in a nursing facility who are suspected or diagnosed as having mental retardation or a related condition.

Appeals

Any nursing facility applicant or resident has the right to request an appeal of any action relate PASARR requirement which, in the opinion of the individual applicant or resident, adversely affects his or her eligibility status, receipt of service, locus of service, and/or assistance. The formal process of review and adjudication of action and/or determinations is done under the authority of Section 1-23-310 et seq., Code of laws, State of South Carolina, 1976, as amended, and the South Carolina Department of Health and Human Services regulations Section 126-150 et seq.

An applicant or resident of a nursing facility who is dissatisfied with an action taken or proposed by any entity involved in the PASARR process which, in their opinion, adversely affects his or her eligibility status, receipt of

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Appeals (Cont'd.)

service, locus of service and/or assistance may appeal that decision. These decisions are subject to appeal whether at preadmission or at annual resident review and include (but are not limited to) the following decisions:

1. Classification of the individual under any of the advance categorical determination groups
2. Failure to classify the individual under any of the advance categorical determination groups
3. Referral of the individual to Level II for individualized determination by the State Mental Health or Disabilities and Special Needs Authority
4. Failure to refer the individual to Level II for individualized determination by the State Mental Health or Disabilities and Special Needs Authority
5. Determination by the State Disabilities and Special Needs Authority regarding the need (or the lack of need) for specialized services and/or the locus to receive the care
6. Determination by the State Mental Health Authority regarding the need (or lack of need) for specialized services and/or the locus to receive the care
7. Nursing facility decisions to discharge or to transfer a resident to another facility due to the need for treatment services identified by the State Mental Health Authority, or due to lack of need for nursing facility or specialized services.

The nursing facility, applicant, resident, or designated representative must make written request for an appeal within 30 days of the date of the official notification issued to him or her and must specify the decision being appealed and the basis for the appeal. The letter should be addressed to:

Appeals and Hearings
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

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SOCIAL HISTORY FOR MR LEVEL II PASARR SCREENING

Client Name: _____ CLTC #: _____

1. Appearance: _____
2. Ability to Communicate: _____
3. Mental Status: _____
4. Observed Behavior: _____
5. Birth and Early Development History: _____
6. Social Development: _____
7. Social/Personal Significant Family History: _____
8. Independent Living Development/Ability: _____
9. Maladaptive/Inappropriate Behavior: _____
10. Medical History: _____
11. Impact of Medical Problems on Individual's Functioning: _____
12. Community Social Supports: _____
13. Summary/Comments: _____

Signature: _____ Date:

DHHS Form 246 (7/92)

User's Guide for Social History for MR Level II PASARR Screening

The intent of the Social History is to obtain further information which relates to the MR indicators and is not normally included on the 1718 and Level I screening.

2. Comment on all forms of communication, i.e. verbal, sign language, etc.
3. Comment on mental status such as alert, oriented, attention span, memory, awareness, thought process, etc.
4. Comment on observed behavior such as facial expression, eye contact, repetitive behavior, etc.
5. Comment on developmental milestones, speech and language development, cognitive development, significant education, and/or vocational history, etc.
6. Comment on relationships with others, interpersonal skills, social functioning, recreational and/or leisure activities.
8. Comment on independent living skills such as financial management, survival skills, ability to make decisions, etc.
9. Comment further on behavioral indicators.
10. Comment on such conditions as seizures, other neurological abnormalities, etc.
12. Comment on past or present association with DDSN and/or community/social supports.
13. Include informants, reliability of information, a brief evaluation of client and legal status, if pertinent.

DHHS Form 247 (7/92)

SOUTH CAROLINA COMMUNITY LONG TERM CARE

CONSENT FORM

Client Name: _____

Social Security Number: _____

I understand as part of my application for long term care services in the community or a Title XIX nursing home, my condition must be evaluated by the South Carolina Community Long Term Care Program.

This evaluation includes information provided by:

a. my physician and medical records;
b. professionals and organizations involved with my care; and,
c. an interview with me and, if necessary, with my family.

I hereby authorize any social service professionals, organizations, doctors, nurses, or other medical personnel or medical facilities involved in my care to release to Community Long Term Care any medical information regarding my diagnoses and recommended treatment.

I hereby authorize Community Long Term Care to release information on my behalf to physicians, hospitals, health and human service organizations, health and human service agencies, family members and/or other persons directly involved with my care.

I understand if my current or future diagnosis includes Alzheimer's Disease, senile dementia or a similar disorder, my records may be reviewed by the statewide Alzheimer's Disease and Related Disorders Registry, and I, or my responsible party, may be contacted for additional information.

Use the space below to indicate the name of any organization, agency or person to whom you do not choose to release information.

_____

_____

_____

This consent shall remain in effect until _____, revoked by me in writing, or until such time as my case is closed by Community Long Term Care.

Date: _____ *Signature of Client or Responsible Party*

If Signed by Responsible Party, State Relationship and Authority to Sign.

Date: _____ *Signature of Witness*

DHHS Form 121 (Revised 10/02)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PASARR - Level I SCREENING FORM

Name:	Date of Review:
SSN:	Location at assessment:
Medicaid: Non-Medicaid:	CUTC#:
Date of birth:	Referral source:
All Diagnosis (If dementia diagnosed or suspected, complete and attach the Mini-Mental Form):	

I. SCREENING FOR MENTAL RETARDATION INDICATORS:

	YES	NO
1. Diagnosis of mental retardation or related disability made prior to age 22?		
2. IQ tested below 70?		
3. Was time of test prior to age 22?		
4. Does client have 3rd grade education? If not, state reason in Comments Section.		
5. Adaptive behavior: Could client ever perform self care activities?		
- Did/does he help care for spouse/parents/children?		
- Was client ever able to cook and perform household duties?		
- Was client gainfully employed? If not, explain in Comments Section.		
- Did client have driver's license?		
6. Cognitive Functioning:		
- Memory: Does client remember what he/she had for breakfast or lunch?		
- Simple math: Can client add 12 + 8?		
- Concept formation: Can client describe the difference between a fish and dog?		

7. Comments: _____

II. SCREENING FOR MENTAL ILLNESS INDICATORS:

1. Diagnosis of mental illness: No__ Yes__ Diagnosis: _____

2. History of psychiatric hospitalization within previous two years. (Give dates of treatment) If no hospitalization, indicate here: _____

__/__/__ to __/__/__ __/__/__ to __/__/__ __/__/__ to __/__/__

3. Current behavioral indicators:

Attempted suicide	__	Unhealthy fear of strangers
Assaultive	__	Self-mutilation
Incessant loud talking	__	Combative
Uncooperative	__	Social isolation
Hostile	__	Destruction of property
		None of these indicators

4. Comments: (Include explanation of major symptoms): _____

DHHS Form 234 (1/96) Previous Editions are Obsolete.

SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

PASARR - Level I
SCREENING FORM

NAME: _____ SSN: _____

III. LIST ALL PSYCHOTROPHIC DRUGS PRESCRIBED INCLUDING DOSAGE AND FREQUENCY:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

IV. RECOMMENDATION OF REVIEWER:

___ Recommend further evaluation based on mental retardation indicators.
___ Recommend further evaluation based on mental illness indicators.
___ No further evaluation recommended.
___ No further evaluation recommended, but indicators present. (State reasons below.)

Comments: (Give justification for above recommendations, if needed.)

V. PERTINENT INFORMATION

___ IMD admission requested; if so, indicate facility: _____
___ Primary diagnosis of dementia must be confirmed by a Mini-Mental Exam.

Information obtained from: _____ CLTC Area # ____

Signature and title of assessor: _____

Agency/Institution completing form: _____

Admitting Nursing Facility: _____ Date of Admission (if known) _____

FOR CLTC/IOC USE ONLY — FOR CLTC USE ONLY

Reviewed by Nurse Consultant ____ (initials)
Date Reviewed: _____

VI. ADVANCE CATEGORICAL DETERMINATION

___ Advance categorical determination that specialized services are not required:

___ 1. Severity of physical impairments overrides need for specialized services (MI only)
___ 2. Nursing facility respite not to exceed 14 days (MR or MI)
___ 3. Emergency admission due to attempted abuse/neglect under authority of DSS (MR or MI)
___ 4. 30-Day time limited certification (MR or MI)
___ 5. Mental retardation with concurrent diagnosis of dementia (MR only)

Signature of CLTC Nurse Consultant: _____

Date sent to nursing facility: _____ Initials: _____

DHHS Form 234 (1/96) Previous Editions are Obsolete.

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South Carolina
Department of Health and Human Services
Resident Case Mix Classification Change

Facility Name: _____

Resident Name: _____ Social Security #: _____

Resident Medicaid #: _____ Attending Physician: _____

Your case has been reviewed by the Interdisciplinary Team to determine if it is medically necessary for you to continue to receive nursing facility care.

1. According to current Medicaid criteria, it has been determined that your classification has been changed to

☐ Skilled Care
☐ Intermediate Care

The above classification change has no impact on your continued stay in the nursing facility.

2. According to current Medicaid criteria, it has been determined that:

☐ You no longer need nursing facility, ICF/MR, or psychiatric IMD care. This does not mean that you do not need personal or other care, and does not mean that you cannot continue to receive skilled, intermediate (including ICF/MR), or psychiatric IMD care. It does mean that the Medicaid program will not continue to pay for such care. The county Department of Health and Human Services will notify you of the proposed date for termination of your benefits.

If you disagree with this determination, please read the reverse side of this notification.

Signature _____ Effective Date _____

Cc: Recipient
Responsible Party
Administrator of Facility
County DHHS Office
*SCDHHS Division of Community and Facility Services

*(Less Than Intermediate Only)

DHHS FORM 210 (REV. 08/11)

APPEALS

AS A MEDICAID PATIENT, YOU HAVE A RIGHT TO A HEARING REGARDING THIS DECISION.

1) YOU HAVE A RIGHT TO APPEAL WITHIN SIXTY (60) DAYS;
2) IF YOU APPEAL WITHIN TEN (10) DAYS YOUR MEDICAID BENEFITS WILL CONTINUE UNTIL A DECISION IS MADE BY THE HEARING PANEL;
3) IF THE HEARING PANEL DOES NOT DECIDE IN YOUR FAVOR, ACTION WILL BE INITIATED TO RECOUP MEDICAID PAYMENTS MADE IN EXCESS OF 30 DAYS BEYOND THE INITIAL ADVERSE DECISION. YOU MUST REPAY THE MEDICAID PROGRAM FOR PAYMENTS DURING THE TIME YOU WERE INELIGIBLE;
4) IF YOU DO NOT WANT YOUR BENEFITS TO CONTINUE WHILE THE HEARING PANEL IS DECIDING ON YOUR CASE, YOU MUST REQUEST IN WRITING THAT YOUR BENEFITS BE STOPPED.

ALL APPEAL REQUESTS SHOULD BE SUBMITTED TO:

APPEALS AND HEARINGS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
POST OFFICE BOX 8206
COLUMBIA, SC 29202

YOU OR YOUR REPRESENTATIVE WILL BE NOTIFIED OF THE DATE, TIME AND PLACE THE HEARING WILL TAKE PLACE.

DHHS FORM 210 (REV. 08/11)

South Carolina Department of Health and Human Services

REQUEST FOR ASSESSMENT OF LEVEL OF CARE

From: _____ DHHS

_____

_____

To: _____

_____

_____

The individual named below has applied for Medicaid. Please complete an assessment immediately and forward it to Community Long Term Care (CLTC) or the Department of Disabilities and Special Needs (DDSN) for a determination of level of care.

Applicant		
Name of Applicant:		Date of Birth:
Home Address:		Telephone Number:
Social Security Number:	Date of Medicaid Application:	Category of Application:
Directions to Home:		

Authorized Representative	
Name of Authorized Representative:	Relationship to Applicant:
Home Address:	
Home Telephone Number:	Work Telephone Number:

Medicaid Worker's Signature: _____ Date: _____

DHHS Form 1231MS (June 2003)

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POLICIES AND PROCEDURES

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM OVERVIEW

GENERAL INFORMATION

The South Carolina Medicaid program recognizes all medical services that are medically necessary, unless limitations are noted within the policy restrictions of this manual. The South Carolina Medicaid program is restricted to services for eligible beneficiaries that are provided services by enrolled or contracted providers and rendered within the South Carolina service area.

Note: Medicaid beneficiaries enrolled in special programs may have limits and restrictions for Medicaid reimbursable services. For Managed Care program participants, providers should review the Managed Care supplement provided with this manual for health care services. Please confirm eligibility and coverage by checking Medifax or the South Carolina Medicaid Web-based Claims Submission Tool (if provider is a member) or by calling (888) 809-3040.

The South Carolina Medicaid program recognizes the services outlined in this manual and will reimburse providers as defined under the heading "Provider Qualifications" below. All other services are considered non-covered services within the South Carolina Medicaid program. The South Carolina service area is usually defined as within twenty-five miles of the state line. Services rendered outside the service area are subject to the outlined prior approval guidelines. All services are subject to the guidelines and limitations established in this manual.

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IN THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
Administrative Law Court

Shirley C. Robinson, Administrative Law Judge
Case No . 2012ALJ080173AP

Albert Cooper Myers, ... Appellant,

v.

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

Appellate Case No. 2014-000418

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Record on appeal contains all material proposed to be included by any of the parties and not any other materials.

February 25, 2015

Patricia L. Harrison
611 Holly Street
Columbia, SC 29205
803-256-2017
Attorney for Appellant

RECEIVED
MAR 18 2015
SC Court of Appeals

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

Appellate Case No. 2014-000418

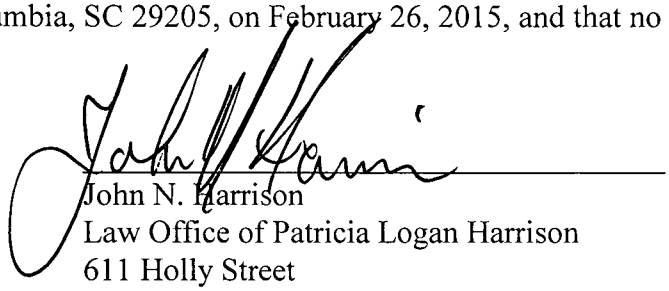
Albert C. Myers, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

CERTIFICATE OF SERVICE

John N. Harrison certifies that he served the Record on Appeal in the above captioned case on the Respondent by hand-delivery to Damon C. Wlodarczyk, Esq., Riley Pope & Laney, LLC, 2838 Devine Street, Columbia, SC 29205, on February 26, 2015, and that no changes were requested.



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