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SC Court of Appeals

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 C. Myers ..... Appellant,

v.

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

Appellate Case No. 2014-000418

RECORD ON APPEAL

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Patricia L. Harrison
611 Holly Street
Columbia, SC 29205
803-256-2017
ATTORNEY FOR APPELLANT

Damon C. Włodarczyk
2838 Devine Street
PO Box 11412
Columbia, SC 29205
803-799-9993
ATTORNEY FOR RESPONDENT

Richard G. Hepfer
PO Box 8206
Columbia, SC 29202-8206

Byron Ronald Roberts
PO Box 8206
Columbia, SC 29202-8206

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SC ADMIN. LAW COURT

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Albert C. Myers, Appellant, v. South Carolina Department of Health and Human Services, Respondent.	Docket No. 12-ALJ-08-0173-AP ORDER

STATEMENT OF THE CASE

This matter is before the Administrative Law Court ("ALC" or "Court") in its appellate jurisdiction pursuant to S.C. Code Ann. § 1-23-600(D). Appellant Albert C. Myers ("Appellant") appeals the final administrative decision of the South Carolina Department of Health and Human Services ("Department") to reduce or discontinue services and/or supplies under the Mental Retardation/Related Disabilities ("MR/RD") waiver program. 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 this matter, considering the Record on Appeal, the briefs, and applicable law, the Department's final decision is AFFIRMED.

BACKGROUND

Factual Background

Appellant is the 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, Appellant 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 waiver renewal became effective, Appellant received the following modified services: physical therapy services were eliminated from the waiver; twenty-eight (28) hours per week of Personal Care Aide II services; sixty-eight (68) units per month of Respite care, with an

exception granting Appellant an additional 33 units per month (for a total of 101 units of Respite Care per month); beginning approximately January 12, 2011, Appellant was authorized 6 hours per week of Personal Care Aide I services; and, psychological counseling. During the pendency of this appeal, Appellant continues to receive physical therapy, 101 hours of respite care per month, and 45 weekly hours of Personal Care Aide II services.

In December of 2011, Appellant became a resident of a long-term care facility.

Procedural Background

On January 13, 2010, the Director of the South Carolina Department of Disabilities and Special Needs ("DDNS") notified Appellant in writing that the decision to reduce his services based upon the MR/RD waiver renewal on January 1, 2010, was upheld. On February 25, 2010, the Department's hearing officer issued an Interlocutory Order asking Appellant 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. Appellant's counsel responded to the Interlocutory Order on March 15, 2010, and counsel for the Department submitted his reply to the allegations contained within Appellant's response to the Interlocutory Order. Based upon the filings made by Appellant, the Department hearing officer issued an Order of Dismissal on May 6, 2010. No evidentiary hearing was conducted prior to the hearing officer's Order of Dismissal.

On May 21, 2010, Appellant submitted a motion for reconsideration of the hearing officer's May 6, 2010 Order of Dismissal. On June 18, 2010, Appellant filed a notice of appeal with the ALC to challenge the Department's May 6, 2010 Order of Dismissal. On November 9, 2011, this Court remanded Appellant's appeal to the Department to conduct an evidentiary hearing. Specifically, the Court found that it was an error to dismiss Appellant's case without conducting an evidentiary hearing. A hearing was conducted before a Department hearing officer on January 6, 2012. On February 9, 2012, the Department hearing officer issued an order upholding the reductions to Appellant's services. Appellant filed a Motion to Alter or Amend the Department's decision; however, the hearing officer denied this motion on March 19, 2012. Based upon the denial of his motion, Appellant filed a notice of appeal with the ALC on April 13, 2012, to challenge the Department's final decision in this matter.

ISSUES ON APPEAL

1. Did the Department's "notices" violate Appellant's due process rights by failing to comply with 42 C.F.R. 431.210(b), which requires the Department to inform Appellant of "the reasons for the intended action" sought to be implemented by the Department?

2. Did the Department fail to identify the statute or regulation it relied upon to support the Department's actions in this matter?

3. Did the Department and an employee of DDSN participate in ex parte communications regarding Appellant's case?

4. Did the Department fail to promulgate the service caps as regulations, thereby causing the service caps to be unenforceable?

5. Was the Department's decision that services ordered by Appellant's treating physician are not medically necessary supported by the substantial evidence in the Record?

6. Did the Department retaliate against Appellant as a result of a family member advocating on his behalf regarding an alleged violation of the anti-retaliation provisions of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act and the Civil Rights Act?

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.")).

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, the Department 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. **Sufficiency of Notice**

Appellant argues that his due process rights were violated because the Department's notices failed to comply with 42 C.F.R. § 431.210(b), which requires the Department to inform Appellant of "the reason for the intended action." Appellant also argues that his due process rights have been violated because the notice informing him of a change to his services did not include the statute or regulation relied upon to support the Department's actions. As noted by the Department, the Court addressed these issues in its November 9, 2011 Order and concluded that Appellant did not preserve the issues for appellate review:

> 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.

November 9, 2011 Order, at 13. Nevertheless, even if it could be construed that Appellant adequately preserved these issues on appeal, Appellant's argument must fail.

"'Generally, due process is flexible and calls for such procedural protections as the particular situation demands.'" Leventis v. S.C. Dep't of Health and Envtl. Control, 340 S.C. 118, 131, 530 S.E.2d 643, 650 (Ct. App. 2000) (citing Ogburn-Matthews v. Loblolly Partners, 332 S.C. 551, 561, 505 S.E.2d 598, 603 (Ct. App. 1998)). "Any party in an administrative agency proceeding is entitled to certain procedural opportunities of notice and a fair hearing." Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm'n, 282 S.C. 430, 435, 319 S.E.2d 695, 698 (1984). "'The requirements of due process include notice, an opportunity to be heard in a meaningful way, and judicial review.'" Leventis, 340 S.C. at 131, 530 S.E.2d at 650 (citing Ogburn-Matthews)). Further, "proof of a denial of due process in an administrative proceeding requires a showing of substantial prejudice." Palmetto, 282 S.C. at 435, 319 S.E.2d at 698; see also Leventis, 340 S.C. at 131-32, 530 S.E.2d at 650.

Although due process is a flexible concept, federal regulations provide specific requirements regarding the notice requirements for state-level Medicaid hearings. The procedures for appealing a decision regarding Medicaid services provided under the Waiver program are set forth in 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). The agency is required to provide notice of the fair hearing, which must contain specific information:

> 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.

42 C.F.R. § 431.210. As the 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).

In this matter, the Department acknowledges that the notice did not include a citation to a specific regulation supporting the reduction or to a new or changed Federal or State law that required the action. Nevertheless, the Department asserts that Appellant was well-aware of the issues prior to his fair hearing before the Department. Accordingly, in order for the Court to overturn the Department's decision because the notices did not meet the technical requirements of the federal regulation, Appellant must show that he was prejudiced by such notices. See Palmetto, 282 S.C. at 435, 319 S.E.2d at 698; see also Leventis, 340 S.C. at 131-32, 530 S.E.2d at 650.

In reviewing the Record, Appellant was sufficiently aware of the proposed changes in his services as a result of the waiver renewal, he was afforded the opportunity to a fair hearing, and he was represented by an attorney throughout the appeals process before the Department. Appellant has not shown how the process or his fair hearing would have been conducted differently had the notices complied with the technical requirements of 42 C.F.R. § 431.210. As such, Appellant has simply not provided any evidence to the Court of how he was prejudiced by the lack of technical compliance with 42 C.F.R. § 431.210. See Kocher v. Dep't of Health and Human Serv. of State of Wis., 152

Wis.2d 170, 179-80, 448 N.W.2d 8, 12 (Wis.App. 1989) (finding that Medicaid service recipient was not prejudiced by inadequate notice and was provided with an "effective opportunity to defend" the Department's termination action where a "case summary" was sent to Appellant's attorney prior to the termination hearing, "elaborat[ing] the nature and reasons for the termination action"); see also Hopkins v. Dep't of Human Services, 802 A.2d 999 (Me. 2002) (holding, in a termination of Medicaid benefits action, that Appellants were unable to show substantial prejudice where the Department failed to meet the technical notice requirements of 42 C.F.R. § 431.210).

Because Appellant has not demonstrated substantial prejudice resulting from the hearing notices provided by the Department, the Court will not overturn the Department's decision as urged by Appellant.

C. Ex parte Communication

Appellant next argues that the Department participated in ex parte communications with DDSN. 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 the Appellant. On February 24, 2010, the same DDSN coordinator sent another memorandum to the Director concerning Appellant's service package. Based upon these memos, Appellant argues that the Department and DDSN participated in ex parte communication regarding his case, and thus, it is impossible to receive a hearing before an unbiased tribunal.

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 agency employees 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 communications. 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 and February 24, 2010 memos could be construed as impermissible ex parte communication, Appellant has not shown how the memos prejudiced him in any way. 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).

D. Promulgation of Regulations

Appellant next argues that the Department erred in its decision because it failed to promulgate regulations prior to implementing the change in service caps. In its brief, the Department acknowledges that "it is questionable whether an un-promulgated Waiver provision can be a 'binding norm' upon a recipient of Waiver services." The Department further asserts that because Appellant was given an evidentiary hearing, his due process rights as established in Goldberg v. Kelly, 397 U.S. 254 (1970), have been met.

As discussed above, South Carolina must seek approval for waiver programs from the CMS. However, CMS's approval of the State's Medicaid Plan or Manual does not make it a binding document.[1] In order for a policy manual 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). "[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 determining whether a policy

[1] The Court is unaware of any federal regulation or law which provides that CMS' approval of our State's Medicaid Plan constitutes sufficient authority to exempt the Department from the requirement to promulgate regulations concerning the administration of standards and procedures relating to services and programs provided under Medicaid.

statement establishes a "binding norm," an important consideration 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. On the other hand, if 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.

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); 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).

Although CMS approved South Carolina's proposed waiver reductions, the new service caps do not have the force and effect of law. The waiver document has never been promulgated as a regulation yet the Department clearly treats it as a binding document. Notwithstanding, the Department is the agency in South Carolina that the General Assembly has granted the sole authority to ultimately resolve issues concerning the provisions of the Medicaid services at issue in this case. As such, the Department's interpretation of Medicaid law and regulations is entitled to due respect and consideration. However, that respect and consideration is limited.[2] Accordingly, based upon applicable law, I conclude that the Manual is not a binding document and does not have the force and

[2] See Comm'r of Public Works v. S.C. Dep't of Health and Envtl. Control, 372 S.C. 351, 641 S.E.2d 763, 767 (Ct. App. 2007) ("Generally, 'the construction of a statute by the agency charged with its administration will be accorded the most respectful consideration and will not be overruled absent compelling reasons.' Indeed, the courts will typically defer to agency interpretation. We note, however, '[t]he primary rule of statutory construction is that the Court must ascertain the intention of the legislature.' Where the terms of the statute are clear, the court must apply those terms according to their literal meaning, without resort to subtle or forced construction to limit or expand the statute's operation. Thus, the court will reject the agency's interpretation where it is specifically contrary to the statute or regulation.") (citations omitted).

effect of law. As a result, this Court must determine whether the Department based its decision solely upon the newly implemented service caps or whether those service caps were considered along with other evidence specific to Appellant's case.

E. Change in Appellant's Services

Appellant primarily argues that the Department's decision should be reversed because the decision of the agency that the services ordered by Appellant's treating physician are not medically necessary is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record, the decision was arbitrary and capricious and characterized by the abuse of discretion and it was affected by error of law. In response, the Department asserts that every category of need presented by the Appellant was either being met, was available through the waiver program, or was available to Appellant through some other mechanism.

In the Department's decision, the hearing officer noted that she was aware of "numerous" federal cases where the courts have found that a reduction in services that lead to a waiver participant's institutionalization violates the Americans with Disabilities Act ("ADA") of 1990. Nevertheless, the hearing officer determined that, based upon the evidence presented before her, the waiver reductions as applied to Appellant did not violate the ADA. Specifically, with regard to the elimination of Speech Therapy under the 2010 waiver renewal, testimony was presented that speech therapy was available outside of the waiver program under the Medicaid State Plan. It is likely Appellant would be eligible to receive this service if his attending physician prescribed the speech therapy to avoid hospitalization. Further, the revised waiver includes a provision for Specialized Medical Equipment, Supplies, and Assistive Technology. As noted by the hearing officer, it is likely that this provision would allow for Appellant to be provided with an assistive speech device. Like speech therapy, physical therapy was eliminated under the revised waiver. Appellant presented sufficient testimony that he will need physical therapy to avoid inpatient hospitalization; however, the Department also presented testimony that a waiver participant may still receive these services under the Medicaid State Plan, provided that specific guidelines are met within the Physicians Manual.

With regard to personal care aide services and respite services, the waiver renewal modified the number of hours Appellant received personal care aide and respite services. At the hearing, testimony was presented to explain the differences and limits of the two types of services, specific to

Appellant's case. The personal care aide services were described as hands-on assistance in the performance of daily living activities, where as respite services are provided on a short-term basis for the relief of the person normally providing the patient's care. As noted by the hearing officer, although the Department modified Appellant's service hours, the combination of the services appear to be in a sufficient amount to cover Appellant's daily needs. With regard to psychological services, the Record demonstrates that Appellant was in need of these services after the loss of his caregiver, and the Department was providing these services to him. Finally, regular medical appointments, some medications, and supplies are available under the State plan, and Appellant's Adult Dental Services are available under the wavier. Accordingly, as determined by the hearing officer, Appellant's regular and emergency medical, dental, and supply needs are available either under the terms of the Waiver or through the State Plan.

The Appellant also argues that the Department failed to give deference to the opinion of his treating physician while considering the provisions of the revised waiver as applied to his case. South Carolina courts have not adopted a rule of per se deference to the opinions of treating physicians. In contrast, it appears our courts have determined that the amount of deference that should be given to a treating physician's opinion depends on the evidence and issue presented in a particular case. See e.g., James v. S.C. Employee Insurance Program, 371 S.C. 637, 640 S.E.2d 474 (Ct. App. 2006) (giving deference to the treating physician's opinion); Wilson v. State Budget and Control Board Employee Insurance Program, 374 S.C. 300, 648 S.E.2d 310 (Ct. App. 2007) (giving deference to the opinion of an independent physician). During the hearing, Department employees testified that Department service coordinators "consider" the opinions of a waiver participant's treating physician. There was also testimony that the service coordinators make decisions by giving "equal weight to all of the information" concerning the waiver participant to obtain "a holistic picture" of his case. Appellant did not present any evidence or testimony to refute the Department's statement regarding the opinions of treating physicians. Based on the evidence in the Record, in Appellant's case, the Department made its decision after weighing all the available information, which included the opinions of Appellant's treating physicians, and there is no requirement that the Department defer to physician opinions in cases such as Appellant's.

In reviewing the Record and in consideration of Appellant's arguments, there is substantial evidence in the Record to support the Department's decision. The revised Waiver, as applied to

Appellant's case, does not violate Appellant's rights. All of the services requested as needed by Appellant are available either through the Waiver, the Adult State Plan, or some other service available through the Department. Although Appellant challenges the Department's reduction of his personal care aide service hours, based upon the testimony presented at the hearing, Appellant's needs can be adequately met through the less expensive Respite or other services. Accordingly, there is substantial evidence in the Record to support the hearing officer's conclusion that Appellant's daily needs were being met under the revised provisions of the waiver.

F. Retaliation

Appellant next argues that he and his guardian have been subjected to retaliation from the Department as a result of his guardian advocating on behalf of Appellant regarding the anti-retaliation provisions of the ADA and the Civil Rights Act. As support for his assertion, Appellant states that he is the only one of the four individuals included in the November 9, 2011 Remand Order that the Department seeks to impose the previously asserted reductions, in accordance with the waiver limits.

Appellant's counsel represented all four individuals named in the November 9, 2011 Remand Order. Based upon that order, the Department scheduled fair hearings for each individual. Subsequently, Appellant's counsel requested that all four fair hearings be cancelled based upon her interpretation of the Remand Order. In response, the Department informed Appellant's counsel that the hearings regarding the other three individuals would be cancelled. More specifically, the Department determined that it would not impose the proposed reductions in two of the cases because of a pending federal lawsuit involving those two individuals. With regard to the third individual, the Department determined that there was a very minimal difference between the previous waiver limits and the proposed waiver limits concerning that individual's annual limit on nutritional supplements.

In reviewing the Record, the Department has adequately explained its rationale for continued litigation in Appellant's case. There is nothing in the Record to suggest that the Department has retaliated against him based upon his appeal to the Department. While Appellant's guardian provided testimony of individuals in the community warning of possible retaliation and regarding other families' experiences, she failed to present any evidence of actual retaliation specific to Appellant. Such speculation does not trigger a violation under the federal law and regulations. Appellant cannot seek relief based on the prospect of home future harm. See Beaufort Realty Co. v.

Beaufort County, 346 S.C. 298, 551 S.E.2d 588 (Ct. App. 2001) (stating that concern over the potential for future harm is insufficient and that a party must present evidence of injury in fact). Accordingly, the Department's decision is supported by substantial evidence in the Record. Further, the Department's decision is not arbitrary, capricious, or an abuse of discretion.

ORDER

For the reasons set forth above,

IT IS HEREBY ORDERED that the Department's decision to modify Appellant's services and/or supplies is **AFFIRMED.**

AND IT IS SO ORDERED.

SHIRLEY C. ROBINSON
Administrative Law Judge

February 3, 2014
Columbia, South Carolina

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the interagency Mail Service addressed to the party(ies) or their attorney(s).
This 3 day of February 2014
By: Judicial Law Clerk

RULING ON MOTION TO ALTER OR AMEND
IN THE APPEAL MATTER OF
A.C.M. (PETITIONER) v. SCDHHS (RESPONDENT)

Appeals' Case #11-MISC-302 (MR/RD Waiver)

JURISDICTION

Procedure in this case is governed under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services to administer various programs and grants (See e.g., S.C. Code Ann. 44-6-10, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (Reg. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. 1-23-310, et seq.).

STATEMENT OF THE CASE

The Petitioner is a Medicaid-eligible individual, who is developmentally disabled, suffering from Atheloid Cerebral Palsy, Scoliosis and possibly Arthrogroposis. 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.

Petitioner 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 South Carolina 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 the federal government permits States to provide services to individuals in ways not allowed under the regular Medicaid Program. This Waiver, #SC.0237.R04.00, is 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.). 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 excluded others.

The DDSN is responsible for the day-to-day operation of this Waiver. The South Carolina Department of Health and Human Services (Department, DHHS, Respondent)

is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the Waiver.

On February 16, 2010, the Petitioner's mother filed an appeal, with the DHHS Division of Appeals and Hearings, of the reduction and elimination of certain Wavier services for her son. She opposed the cut in hours of Personal Care Attendant support and the elimination of daily 24 hour in home respite, physical therapy, occupational therapy, speech therapy and the denial of coverage for an augmented communication device. Hearing Officer Janet Goode sent the Petitioner's representative an Interlocutory Order on February 25, 2010 directing her to respond with a more definite statement of a cause of action upon which relief could be granted. Via Order of Dismissal of May 6, 2010, this Hearing Officer dismissed the Petitioner's appeal as Petitioner failed to state a legitimate Cause of Action for her appeal. The Petitioner appealed the Order of Dismissal to the South Carolina Administrative Law Court (ALC) which resulted in Administrative Law Judge (ALJ) Shirley C. Robinson remanding the case for an administrative hearing with the DHHS Division of Appeals and Hearings. I convened a hearing in this matter on January 6, 2012 and a Final Administrative Order was issued on February 9, 2012. Via Motion to Alter or Amend of February 26, 2012, the Petitioner requests that this Hearing Officer reconsider her Final Administrative Order.

ISSUE

The immediate determinative issue is whether this Hearing Officer should modify her Final Administrative Order of February 26, 2012.

FINDINGS AND CONCLUSIONS OF LAW

The Petitioner has moved that the Final Administrative Order in this matter be altered or amended for the following reasons, to which this Hearing Officer finds:

(1) The Petitioner asserts in items 1, 6, and 17 that I failed to rule that the caps on services and elimination of other services were invalid *ab initio* because DDSN and DHHS attempted to establish a binding norm without promulgating regulations which are required by the South Carolina Administrative Procedures Act, citing the case of Hickey v. SCDHHS, 10-ALJ-08-0656-AP.

Conclusion—the Medicaid Program was designed to allow local (state) control over services to disabled and low-income individuals. The states, subject to federal approval, determine who will be eligible, the services offered, the payment levels to providers and administrative procedures 42 CFR § 430.0. Therefore, SCDHHS is tasked with administration of the Medicaid program and in the case of

Hickey v. SCDHHS, the enforcing of Waiver limitations is not prevented as long as an evidentiary hearing is offered.

(2) The Petitioner asserts in items 2, 3, 4, 5, 7, 8, 12, 13, 14, and 24 that I failed to find the Respondent is not providing services sufficient to meet the Petitioner's needs.

Conclusion—as part of the State Plan, the Medicaid Program will continue to provide services such as Physical Therapy and Nursing Services which were formerly covered as Waiver services. The most recent MR/RD Waiver renewal, approved by the Centers for Medicare and Medicaid Services (CMS) on November 9, 2009, for the time period of January 1, 2010 through December 31, 2014, included services such as Personal Care Aide Services (PCA 1 & 2), Respite and Assistive Technology that the Petitioner has indicated are necessary for him to be able to live in the community. Since these services are still available and may be combined in various configurations to meet beneficiaries' changing needs, I do not agree that the Petitioner is unable to receive the type and duration of services he medically requires.

(3) The Petitioner asserts in items 2, 9, and 19 that I failed to find give appropriate deference to the opinion of the Petitioner's physician.

Conclusion—while the treating physician's orders were considered, the Petitioner failed to demonstrate the mix of services offered by the Respondent would fail to meet his medical requirements as prescribed by his physician.

(4) The Petitioner asserts in items 10, 21, and 22 that I failed to find the Respondent violated law and regulations on due process and the sufficiency and promptness of the notice of service changes.

Conclusion—I find both allegations, lack of due process and insufficient notification of changes, unsound because the Petitioner was aware of changes in his services, had a hearing in this matter and received continued benefits at the level prior to the changes in the interim.

(5) The Petitioner asserts in item 11 that I failed to consider the elements a court must consider in determining whether an agency has violated the Americans with Disabilities Act (ADA) and the United States Supreme Court's orders in Olmstead v.L.C. .

Conclusion—in my decision of February 9, 2012, Conclusion of Law #6 is a detailed account of services available to allow the Petitioner to remain in the community, thus negating the Petitioner's assertion violations of the ADA and Olmstead v.L.C. were not taken into consideration.

(6) The Petitioner asserts in item 15 that I fail to find that the change in services and failure to provide services resulted in the Petitioner's institutionalization.

Conclusion—as referenced previously, Conclusion of Law #6 of the February 9, 2012 decision is a detailed account of services available to allow the Petitioner to remain in the community, and as the Petitioner was allowed to continue to receive services at the level received when the notification of benefit changes was made, I do not credit the threat of change as responsible for the decision to place him in a nursing facility. Additionally, testimony from the Petitioner's mother did not support this allegation.

(7) The Petitioner asserts in items 16 and 18 that I failed to find a retaliatory motive in the reduction of services and the prosecution of this case.

Conclusion—I believe the ADA's protection for individuals against retaliation from governing entities does not apply in this matter because I do not find the changes in the Wavier services will result in less care for the Petitioner. Neither do I believe that the Respondent's determination to impose reductions in specific services, supplemented by increases in services that appear to be more appropriate, was, in any way, punitive or retaliatory.

(8) The Petitioner asserts in item 20 that I failed to find the Respondent in error for not completing a proper PASARR evaluation and determining that the Petitioner requires specialized services.

Conclusion—as this issue was not included in the original appeal filed with the DHHS Division of Appeals and Hearings or included in the ALC remand, PASARR evaluation, or the lack there of, is not within my jurisdiction. To the best of my knowledge, no appeal has been filed pertaining to a PASARR assessment for the Petitioner.

(9) The Petitioner asserts in item 23 that my findings and those of the Respondent were arbitrary and capricious.

Conclusion—Finding of Facts in my decision of February 9, 2012 are supported by substantial evidence, persuasive testimony and copious documents contained in the record.

(10) The Petitioner asserts in item 25 that I failed to rule on the Petitioner's allegation that *ex parte* communication had occurred between the DHHS Division of Appeals and Hearings and DDSN.

Conclusion—the allegation of ex parte communication was considered by the ALJ in her November 9, 2011 Order, therefore, it was not proper for me to rule on the issue since it had been settled by the ALC.

DECISION

The Final Administrative Order of February 9, 2012 stands as written.

AND IT IS SO ORDERED.

Betsy Schindler
Hearing Officer

Dated at Columbia,
South Carolina

March 19, 2012

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FINAL ADMINISTRATIVE ORDER IN THE APPEAL MATTER OF
A.C.M. (PETITIONER) v. SCDHHS (RESPONDENT)

Appeals Case #11-MISC-302 (MR/RD)
Hearing Date: January 6, 2012

JURISDICTION

Procedure in this case is governed under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (SCDHHS) to administer various programs and grants (See e.g., S.C. Code Ann §44-6-5, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the SCDHHS (S.C. Code Ann. R. 126-150 et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. §1-23-310 et seq.)

STATEMENT OF THE CASE

The Petitioner is a Medicaid-eligible individual, who is developmentally disabled, suffering from Atheloid Cerebral Palsy, Scoliosis and possibly Arthrogroposis. 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.

Petitioner 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 South Carolina 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 the federal government permits States to provide services to individuals in ways not allowed under the regular Medicaid Program. This Waiver, #SC.0237.R04.00, is 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.). 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 excluded others.

The DDSN is responsible for the day-to-day operation of this Waiver. The South Carolina Department of Health and Human Services (Department, DHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the Waiver.

ISSUES

The issue before me in this case is whether the SCDDSN acted correctly in reducing the Petitioner's services in accordance with the renewed Waiver. The Petitioner asserts that:

1. The January 1, 2010, Waiver limitations have been found to be unenforceable by the Administrative Law Court's Decision in Hickey v. SCDHHS (10-ALJ-08-0656-AP);
2. The Petitioner lacks adequate notice of the intended actions of reducing his services;
3. The reductions in the Petitioner's services will likely cause him, and have caused him, to be institutionalized and are therefore violative of the integration mandate included in Olmstead v. L.C., 527 U.S. 581 (1999);
4. The actions of the Respondent in going forward with the reductions in the Petitioner's services are retaliatory against the Petitioner.

The Respondent counters that:

1. The Hickey case only means that the reductions cannot be imposed without an opportunity for an evidentiary hearing;
2. Because this matter has previously been before the DHHS Appeals Division and before the ALC, there has been sufficient opportunity for the Petitioner to be aware of the intended actions of the Respondent and there impact upon him;
3. That there are sufficient services contained in the Renewed Waiver document in order to adequately maintain the Petitioner in the community, and, therefore, the Olmstead integration mandate was not violated;
4. There were adequate reasons to refrain from imposing the reductions on the other cases covered in Judge Robinson's remand, and, therefore, no retaliation can be shown.

PROCEDURAL POSTURE

This case originally started as an administrative appeal of reductions in services specified in a Waiver renewal. As of the effective date of the Waiver renewal (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
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 in the Waiver, at page 55 of 195 of Respondent's exhibit #5.
4. The two (2) half day services were combined into a full day (at least five hours) of Adult Day Health Care (ADHC) services.
5. Dental, medical and supplies remained the same.
6. On or about January 12, 2011, the Petitioner was authorized 6 hours per week of Personal Care Aide I services.
7. Following the 2011 Plan of Service meeting, the Petitioner was authorized psychological counseling.

(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 essentially unchanged.)

This appeal is now a remand from the Administrative Law Court (ALC), which came about in the following way:

1. The original appeals through the Departments' processes were unsuccessful for the Petitioner, and the DHHS Hearing Office in that case dismissed the appeal;
2. The Petitioner appealed to the Administrative Law Court (ALC);
3. 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, which are dispositive of the issues.

INFORMATION BEFORE THE HEARING OFFICER

1. I am generally familiar with the operations of the Departments and with the Waiver at issue here;

2. I have the Prehearing Brief of the Respondent and the ALC Order remanding the matter to this forum for a hearing;

3. I have the testimony of the following individuals:
   a. Ms. Janet Priest of the DDSN testified about the operation of the MR/RD Waiver and the services available in the Waiver before and after the January 1, 2010 renewal;
   b. Ms. Juanita Auker, the Petitioner's Service Coordinator, from the county Department of Special Needs (DSN) Board was familiar with the services the Petitioner was receiving;
   c. Ms. Kara Lewis, of the central DHHS office, testified about the process of submitting changes to the Waiver document and the discussions that led up to the January 1, 2010, renewal;
   d. Ms. Sandra Ray, a speech pathologist, who is also involved in a probate matter regarding the Petitioner, testified about the Petitioner's needs for a speech device, nursing services, physical therapy and grief counseling;
   e. Ms. Lennie Mullis, a psychological counselor, who has been providing grief counseling with the Petitioner, testified also about his need for physical therapy, a speech generating device, dental services, nursing services, and the psychological counseling she was providing to the Petitioner;
   f. Ms. Lisa Jones, the Petitioner's personal care aide, testified about his daily routine prior to admission to the nursing home, and the care she rendered;
   g. Ms. C.M. the Petitioner's mother testified about his condition and needs, the Petitioner's experience at the regional center and at the ICF/MR Respite service, her long term advocacy for her son and others and her feelings about his current placement.

4. I have the following documents.

a. Petitioner's Exhibits:

Exhibit 1. A letter from the Petitioner's attorney attaching Judge Robinson's ruling on the Petitioner's Motion to Alter or Amend her original Order and asserting that, under the Hickey case, the reductions are invalid and that notice of the actions that the Department is taking with respect to the Petitioner is lacking;

Exhibit 2. A 242 page collection of documents containing the statutory and regulatory requirements for nursing facilities, the DHHS Nursing Home Manual sections on level of care evaluations and the preadmission screening and resident review provisions with forms, and the following opinions:

a) Jane Doe v. SCDHHS, Opinion No. 27083 (SC 2011).
b) Final Administrative Decision in the Matter of D.L.B.;
c) The Order on the Petitioner's Motion to Alter or Amend Judge Robinson's Remand;
d) The ALC's Order in Hickey v. SCDHHS, 10-ALJ-08-0656-AP;
e) An Article about the Decision in Crabtree v. Goetz (M.D. Tenn.);
f) Rolland v. Celliucci, 138 F.Supp.2d 110 (D. Mass 2001)
g) Rolland v. Cellucci, 198 F. Supp.2d 25 (D. Mass. 2002);
h) Rolland v. Romney, 273 F. Supp. 2d 140 (D. Mass. 2003);
i) Rolland v. Patrick, 483 F. Supp. 2d 107 (D. Mass. 2007);
j) M. R. v. Dreyfus, Opinion No. 11-35026 (9th Cir.);
k) Meter v. Harvey, No. 1:09-cv-00633-JAW (D.C. Maine 2011)
l) Pashby v. Cansler, No. 5:11-cv-273-BO (E. D. NC. 2009);
m) Ryan v. Drefus, No. C09-0908RAJ (W.D. Wash. 2010);

This Exhibit also contains a number of descriptions of other state's PASARR procedures and some inflation figures for 2008 through 2009 and an explanation of changes during 2007 through 2009;

Exhibit 3. A Thirty-one pages exhibit containing PASARR State Plan provisions, Petitioner's PASARR review, terminations of services and Service Coordinator notes;

Exhibit 4. A letter form Susan B. Munn, MD regarding the Petitioner's needs;

Exhibit 5. A letter form the Petitioner's physical therapist;

Exhibit 6. Dr. Munn's Affidavit;

Exhibit 7. Dr. Munn's office visit notes for part of 2011;

Exhibit 8. Dr. Buscemi's, December 9, 2011 notice about the Waiver Reductions;

Exhibit 9. A collection of documents:

a) The Report and Recommendation of the Magistrate Judge in Peter B. v. Sanford, et al.;

b) The Decision in Olmstead v. L.C., 527 U.S. 581 (1999);
c) 29 USC §794a(2);
d) Barker v. Riverside County Office of Education, No. 07-56313 (9th Cir. 2009);
e) The Order and Opinion in Peter B. v. Sanford, C.A. No.: 6-10-cv-00767-JMC (D.S.C. 2011) granting a Temporary Injunction.

b. Respondent's Exhibits:

Exhibit 1. A letter from the Respondent's attorney indicating that no further actions will be taken with respect to three (3) of the individuals in Judge Robinson's Consolidated Cases, but that the Department does intend to go forward with the reductions in the Petitioner's case, and therefore, an evidentiary hearing will be required;
Exhibit 2. The Respondent's Pre-hearing Brief;
Exhibit 3. The case of Freeman v. State of Washington, No. C09-5616-RJB (W.D. Wash. 2010);
Exhibit 4. The case of M.R., et al. v. Dreyfus, No. C10-2052Z (W.D. Wash. 2011);
Exhibit 5. The January 1, 2010, Waiver Document;
Exhibit 6. The ID/RD DDSN Waiver Manual provision on Personal Care Services (age 21 and over);
Exhibit 7. The Medicaid Scope of Services for Personal Care II;
Exhibit 8. The ID/RD DDSN Waiver Manual provision on Respite Care.

FINDINGS OF FACT

I listened carefully to the testimony of the witnesses, observing their demeanor, and reviewed the multitude of documents submitted. In addition, as mentioned, I am somewhat familiar with the Departments' operations and the Waiver at issue here. Based upon that information, I make the following findings of fact:

1. On January 1, 2010, the Waiver Renewal went into effect, limiting certain MR/RD Waiver services and eliminating others;

2. The Petitioner is a 34 year old developmentally disabled man with atheloid quadriplegia, contractures, severe scoliosis, epilepsy, cerebral palsy, and he is basically non-verbal;

3. Since the Petitioner cannot speak, he appears to need a speech generating device of some kind and, based on the testimony of Ms. Priest, that equipment is available, in accordance with agency criteria, either through the Waiver or as a State Plan Service;

4. The Petitioner appears to need physical therapy to reduce contractures and maintain range of motion, and, as set forth in the Respondent's Physicians Provider Manual, that service is available as a State Plan Service, with the proper documentation by the attending physician;

5. During the day, the Petitioner needs assistance with his activities of daily living (eating, dressing, toileting and bathing), and when he was living at home, that was provided by a mix of Personal Care Aids and Respite Care workers, as follows:
   a) About two (2) hours in the morning would be spent by a Personal Care Aide II (PCAII) getting the Petitioner up and cleaned and dressed;
   b) In the morning he would be tube-fed by his mother;
   c) After that, the Petitioner went to an ADHC until about 2:30 in the afternoon;
   d) At the ADHC, there was support for his Activities of Daily Living (ADLs), he was fed through his feeding tube, and there was some nursing supervision;
   e) The Petitioner arrived home by van about 2:30 in the afternoon;
   f) In the afternoon, again, about two (2) hours was spent by the PCAII providing hands on care to accomplish the Petitioner's ADLs;
   g) The Respite worker was available in the late afternoon to observe and supervise the Petitioner, but the mother would actually perform the tube feeding by attaching the bag with the nutrition to a hanger on his wheelchair and feeding through the tube;

6. That the services listed in #5 above are available within the renewed Waiver limits, because 28 hours per week of PCAII services is allowed, Respite Care services of up to 68 hours per month (or about 16 hours per week) are available, and depending upon the assessment of the Petitioner's needs, exceptions may be granted to allow up to 240 units per month (or about 56 hours per week) based on specific exception criteria;

7. Based on the testimony of Ms. Lennie Mullis, the Petitioner needed psychological counseling services following the loss of his primary caregiver as the result of an injury, and that service was provided through the Waiver;

8. A set of lifts had been installed, through the Waiver Program, in the Petitioner's living area to move him from bed to chair and from chair to bath;

9. If his mother were not available to administer his tube feedings at home, the Petitioner may need a licensed nurse to administer the feedings because a PCAII is not allowed to perform that service, but nursing services are available under the terms of the Waiver;

10. The Petitioner's medications, medical, emergency, dental coverage and incontinence supplies that he unquestionably needs are also available within the terms of the renewed Waiver or are available outside the Waiver as State Plan services;

11. In December of 2011, the Petitioner was admitted to a long term care facility.

CONCLUSIONS OF LAW

I reviewed the documents and presentations of the Parties and read the caselaw submitted. Based upon that information, I make the following Conclusions:

1. I conclude that in accordance with §1915(c) of the Social Security Act [42 USC §1396n(c)] States may be permitted to waive certain generic requirements of the Medicaid Program and provide services in certain ways to allow persons with mental retardation or a related disability who would normally have to live in an institution to live in the community;

2. I conclude that in accordance with 42 CFR §440.180, for home and community based waivers, the services available are those that are defined by the state Medicaid agency and approved by the Centers for Medicare and Medicaid;

3. I conclude that the DHHS is the single State Agency as specified in 42 U.S.C. §1396 et. seq. and S.C. Code Ann. §44-6-10 et. seq. to administer the Medicaid Program in South Carolina;

4. I have read the Hickey ALC case, and understand it to mean that the Hearing Officer may not apply the Waiver limitations as though they were "binding norms" or rules that the Hearing Officer had to apply without the necessity of an evidentiary hearing, and in accordance with the remand in this case, I have conducted an evidentiary hearing;

5. On the other hand, I have read the case of Doe v. SCDHHS, No. 27083 (SC, 2011) submitted by the Petitioner, and although in that case the Department's definition of "mental retardation" was struck down because it was not consistent with other state and federal rules, the court did in that case seem to affirm the ability of the South Carolina Medicaid agency to specify criteria in the Waiver application, which, apropos to this case, it seems to have done;

6. It is true that numerous federal courts have issued injunctions, finding that a reduction in services that tends to lead to a Waiver participant's institutionalization is violative of the Olmstead integration mandate. See the Peter B. Recommendation and Order submitted with the Petitioner's Exhibit #9 and the 9th Circuit's recent reversal in M. R. v. Dreyfus, in Petitioner's Exhibit #2 (citation above). However, for the following reasons, even mindful of the temporary restraining order in the Peter B. and Dreyfus cases, I cannot conclude that the Waiver reductions as applied to the Petitioner are violative of Olmstead and the Americans with Disabilities Act.

   a) The Waiver application, which is the approved Waiver document, Respondent's Exhibit #5 includes, at page 93 of 195, a definition of Specialized Medical Equipment, Supplies, and Assistive Technology as including "...devices, controls, or appliances, specified in the plan of care, which enables individuals to increase their abilities to perform activities of daily living, or to perceive, control or communicate with the environment in which they live," and I believe that would include an assistive speech device as the testimony indicated that the Petitioner needed for him to be connected to the community;

   b) It is true that physical therapy has been eliminated as a service under the Waiver. However, the testimony indicated that a Waiver participant may still receive services under the Medicaid State Plan (outside the Waiver), and, as cited in the Respondent's Prehearing Brief (Respondent's Exhibit #2) that service does seem to be available to adults in accordance with specific guidelines set forth in the Physicians Manual among which is to avoid inpatient hospitalization, which the Petitioner's physician says that he will need unless he continues to receive physical therapy to avoid contractures and other complications.

   c) Personal Care Aide Services (PCAI & II) and Respite Services as described in the Waiver document and in Respondent's Exhibits #s 6 & 8 are similar services. Also, according to the descriptions, the services are provided by similarly qualified providers. However, the PCAII services are described as hand-on assistance in the performance of the Activities of Daily Living, while Respite services are furnished on a short term basis for relief of the person normally providing care. Thus, it seems to me that PCAII services are designed to be more intense and strenuous. Respite service, on the other hand, although it may at times require hand-on care, seems more supervisory and observational. In combination, therefore, these services seem to be available in sufficient amount to cover the Petitioner's daily needs as described above.

   d) At page 91 of 195 of the Waiver document, Psychological Services are described as "Services focused upon assessment of needs and counseling/therapy designed to address needs in areas such as cognitive functioning and/or

affective skills." Therefore it seems that psychological counseling, which the Petitioner was described as needing due to the loss of a trusted caregiver is available within the limitations of the Waiver, and was being provided.

e) Under the terms of the Waiver document, at page 85 of 195, "Nursing services are continuous or intermittent skilled care provided by a nurse, licensed in accordance with the State Nursing Practice Act, in accordance with the participant's plan of care as deemed medically necessary by a physician." Therefore, the renewed Waiver document would seem to provide for coverage for the Petitioner's tube feedings, in the absence of his mother.

f) Regular medical appointments as well as a limited number of medications are available under the regular State Plan, and supplies are available under the Waiver. Adult Dental Services are only available under the Waiver as described on page 58 of 195 of the Waiver document. Accordingly, it seems that the Petitioner's regular and emergency medical dental and supply needs could be met under the terms of the Waiver or through the State Plan.

7. The Petitioner also argues that he is being retaliated against and presents caselaw that shows that retaliation while making a claim under the ADA is unlawful. See Petitioner's Exhibit #2. The claim seems to stem from the fact that there were initially four (4) cases that were remanded by Judge Robinson and the Petitioner's is the only one in which the Department has chosen to go through with the reductions. However, looking at Respondent's Exhibit #1, it seems that the reason for abandoning the reductions in two (2) of the cases was that there was a pending federal district court case, the Peter B. case, in which those two (2) participants were also Plaintiffs. The other case involved a very minimal reduction in services, which the agencies determined not worth the contest. Therefore, I cannot find a retaliatory motive in the decision to continue to impose the Waiver reductions on the Petitioner. Furthermore, as set forth above I do not believe the Waiver limitations amounted to a reduction in care to the Petitioner, but only a reconfiguration in services which were still sufficient to meet his needs.

DECISION

It appears to me that the Departments had the authority to renew the MR/RD Waiver and limit or exclude services from the Waiver in the renewal. The Petitioner appealed the original reduction and appeared in that case. Then the Petitioner successfully appealed that case to the Administrative Law Court. I believe that the Petitioner has had adequate notice of the intended reductions and the issues.

It further appears to me that, as applied in this case, the new Waiver is not violative of the Olmstead integration mandate. All of the services alleged to be needed by the Petitioner are available through the Waiver. Furthermore, according to the testimony of his caregivers, it appears to me that his needs could be adequately met within the new Waiver limits. The only absolute reduction in services was the reduction in PCAII services, which according to design is for hands-on assistance with ADLs. Based on the description of care rendered by the Aide, it does not seem that the Petitioner needed over seven (7) hours per day of that intense service. I believe the other times when supervision and observation was needed could have been met with the less expensive Respite services.

It also appears to me that the true reason for the Petitioner's institutionalization was simply the passage of time and the desire of the Petitioner's caregiver, and perhaps the Petitioner himself, to establish another support system, one that will be available for the long term future.

Therefore, the Respondent's actions in this matter are sustained.

AND IT IS SO ORDERED.

Betsy Schindler

Betsy Schindler
Hearing Officer

DATED AT COLUMBIA
South Carolina

February 9, 2012

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Susan Edge, Jimmy W. Eubanks, Jr., Michelle Morgan, and Albert Cooper Meyers, Appellants, vs. South Carolina Department of Health and Human Services, Respondent.	)	Docket No. 10-ALJ-08-0501-AP **ORDER ON APPELLANTS' MOTION TO ALTER OR AMEND**

This matter is before the South Carolina Administrative Law Court ("ALC" or "Court") pursuant to separate appeals filed by the above-named Appellants. Because the appeals involved almost identical issues and the Appellants were represented by the same attorney, the Court determined that it was appropriate to consolidate the cases, and issued an Order effectuating the consolidation on October 4, 2010. Further, following review of the Record on Appeal and briefs filed by the parties, this Court issued an Order on November 22, 2011 reversing the Respondent's decision to reduce and/or terminate services and/or supplies provided to the Appellants. The Order also required the Respondent to provide each Appellant with an evidentiary hearing before taking any further actions with regards to Appellants' benefits under the MR/RD waiver program.

On November 21, 2011, the Appellants filed a Motion requesting that this Court alter or amend its November 11, 2011 Order. The Respondent filed a Return to the Motion on December 1, 2011.

Although the Appellants agree with this Court's ruling, the Appellants are nevertheless requesting that this Court alter or amend the Order as it relates to certain factual findings and holdings contained in the Order. Specifically, the Appellants contend that in view of the Court's decision to remand the cases for administrative hearings, it was not necessary for the Court to address other issues raised in the appeals. These issues relate to defective notice and ex parte communications. However following my review of the Motion and Return, and the Order, I find

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that these issues were appropriately addressed in the Order, and the Appellants' Motion to Alter or Amend the Order to address these issues differently should be denied.

The Appellants also contend that this Court's finding that the federal district court had not yet ruled on the preliminary injunction request involving Appellants Eubanks and Morgan was in error. Appellants are correct, and this Court finds that on March 7, 2011, United States District Judge J. Michelle Childs issued an Order granting the Motion for Preliminary Injunction.

IT IS THEREFORE ORDERED, that this Court's finding that "To date, a federal district judge has not ruled upon Eubanks and Morgan's motion for preliminary injunction" was made in error.

IT IS FURTHER ORDERED, that the remainder of Appellant's Motion to Alter or Amend the Order of this Court dated November 22, 2011 is denied.

AND IT IS SO ORDERED.

SHIRLEY C. ROBINSON
Administrative Law Judge

December 7th, 2011
Columbia, South Carolina

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the interagency Mail Service addressed to the party(ies) or their attorney(s).
This 7 day of December 2011
By: Judicial Law Clerk

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

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SC ADMIN. LAW COURT

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 Dismissal on May 6, 2010. No evidentiary hearing was conducted prior to the hearing officer's Order of 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(c), 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.").

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 11, 2011
Columbia, South Carolina

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the interagency Mail Service addressed to the party(ies) or their attorney(s).
This 9 day of November 2011
By: Jeeblu Henderson
Judicial Law Clerk

RECEIVED OCT 0 5 2010

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Susan Edge, Appellant, vs. SC Department of Health and Human Services, Respondent.	Docket No.: 10-ALJ-08-0501-AP
Jimmy W. Eubanks, Jr., vs. SC Department of Health and Human Services, Respondent.	Docket No.: 10-ALJ-08-0502-AP
Michelle Morgan, Appellant, SC Department of Health and Human Services, Respondent.	Docket No.: 10-ALJ-08-0503-AP
Albert Cooper Myers, Appellant, vs. SC Department of Health and Human Services, Respondent.	Docket No.: 10-ALJ-08-0504-AP ORDER GRANTING APPELLANTS' MOTION FOR EXTENSION OF TIME AND CONSOLIDATION

FILED
OCT 04 2010
SC ADMIN. LAW COURT

This matter is before the South Carolina Administrative Law Court ("ALC" or "Court") pursuant to the above Appellants' Motion for Extension of Time and Consolidation ("Motion") that

was filed with the Court on September 15, 2010. Rule 37 (A) of the ALC Rules of Procedure gives appellants 30 days following the filing of the record on appeal to file an appeal brief. Absent an order granting an extension of time to the parties in this case, Appellants' briefs would have been due on September 16, 2010. Appellants have requested that the time to file the initial appeal briefs be extended in the above cases because "[w]hile preparing Appellants' briefs, counsel discovered that the Record on Appeal is incomplete."[1] In addition, Appellants requested that the cases be consolidated because the same question is involved in each of the above appeals. The Respondent did not file an objection to the Motions. Following a review of Appellants' submission, the Court finds that Motions for an extension of time to file the initial brief and consolidation of the appeals should be granted.

IT IS THEREFORE ORDERED that Appellants shall file with the undersigned judge and serve on the opposing parties a Brief of Appellants within thirty (30) days of the date of this order.

IT IS FURTHER ORDERED that the appeals listed above shall be consolidated for all future pretrial and trial purposes under **Docket Number 10-ALJ-08-0501-AP.**

AND IT IS SO ORDERED.

SHIRLEY C. ROBINSON
Administrative Law Judge

October 4th, 2010
Columbia, South Carolina

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this Order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or the Interagency Mail Service addressed to the party(ies) or their attorney(s).
This 4th day of October
By: Brenda Kirkpatrick
Judicial Law Clerk

[1] Appellants' Motion for Extension of Time and Consolidation at 1.

ORDER OF DISMISSAL
IN THE APPEAL MATTER OF
A.C.M. (PETITIONER) VS. SCDHHS (RESPONDENT)

Appeals' Case #10-MISC-040 (MR/RD)
Hearing Date: Not held

JURISDICTION

This case is adjudicated under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (DHHS) to administer various programs and grants (See, e.g., S.C. Code Ann. 44-6-10, et seq.). The appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (Reg. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. 1-23-310, et seq.).

STATEMENT OF THE CASE

On January 13, 2010, Beverly A. H. Buscemi, Ph.D., State Director, DDSN notified Petitioner in writing that the decision to reduce Petitioner's Personal Care II Services and Respite Services with elimination of Physical Therapy was upheld on reconsideration due to not being at liberty to exceed the established limits of the Mental Retardation/Related Disabilities (MR/RD) Waiver.

On February 11, 2010, the Petitioner's appeal request was received via fax in Appeals and Hearings. The Petitioner appealed reduction and elimination of Medicaid sponsored Waiver service hours provided through Department of Disabilities and Special Needs (DDSN). Appeal request specifically stated Petitioner opposed the cut to PCAII support hours, the elimination of daily/24 hour in home respite, the elimination of Physical Therapy, Occupational Therapy and Speech Therapy services and the denial of coverage for Augmented Communications evaluation and equipment. A hard copy of the Petitioner's appeal request with a copy of Dr. Buscemi's reconsideration response dated January 13, 2010 was received in Appeals and Hearings on February 16, 2010.

ISSUE

The issue is whether the South Carolina Department of Health and Human Services (DHHS) by its agent, DDSN, has the authority to develop and determine policies and procedures for the implementation of Medicaid programs and services, and to alter or amend those policies and procedures as may be necessary as provided for under applicable Federal Law and Regulations. Any issues raised in the proceedings or hearing of this case but not addressed in this Decision are deemed denied.

FINDINGS OF FACT

Based on the documentary evidence of record, I make the following Findings of Fact based on a preponderance of the evidence:

1. On February 25, 2010, an Interlocutory Order/Cause of Action was sent to Petitioner's mother/representative describing the facts of, and the basis for the decision in this case, and asking for a written statement of any allegation of any error made by the agency in its modification of Medicaid sponsored Waiver services provided through DDSN, and I so find (See, Case File);

2. On March 15, 2010, Patricia L. Harrison's response to the Interlocutory Order was received via fax in Appeals and Hearings. Ms. Harrison advised in her cover letter that she represents the Petitioner, and I so find (See, Case File);

3. On March 16, 2010, Hearing Officer sent a copy of documentation in file, Interlocutory Order dated February 25, 2010 and Petitioner's response to the Interlocutory Order received March 15, 2010 to the Respondent. The Respondent was given the opportunity of commenting on Petitioner's response by March 30, 2010, and I so find (See, Case File);

4. On March 17, 2010, a hard copy of Ms. Harrison's response to the Interlocutory Order with cover letter advising she represents the Petitioner was received in Appeals and Hearings, and I so find (See, Case File);

5. On March 30, 2010, Rick Hepfer, Deputy General Counsel, DHHS, response to Petitioner's allegations was received in Appeals and Hearings. Mr. Hepfer informed the Hearing Officer that Petitioner's representative had been copied with response and he would be appearing for the Respondent, and I so find (See, Case File);

6. On March 30, 2010, Hearing Officer sent a copy of Respondent's response to Petitioner offering her the opportunity to comment further. Petitioner was requested to respond within ten business days from the date of receipt of Hearing Officer's correspondence, and I so find (See, Case File);

7. On April 5, 2010, Domestic Return Receipt was received in Appeals and Hearings verifying correspondence sent by the Hearing Officer was received by Petitioner on April 2, 2010, and I so find (See, Case File);

8. As of the date of this writing, Petitioner has failed to comment further, and I so find;

9. On January 1, 2010, the five-year renewal of the MR/RD Waiver, as approved by the Center for Medicare and Medicaid Services (CMS), went into effect. The renewed Waiver included a cap or limit on some services, and I so find (See, Case File);

10. Petitioner is a recipient of Medicaid Services and is on the MR/RD waiver, and I so find (See, Case File);

11. Prior to MR/RD Waiver renewal on January 1, 2010, Petitioner's authorized service package through the waiver included: 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 2, 48 units annually of Daily Respite and 456 units annually of Hourly Respite, and I so find (See, Case File);

12. Petitioner's authorized service package under the renewal of the MR/RD Waiver on January 1, 2010 includes: Dental, 5 units per week of Community Service, 5 units per week of Day Activity, Specialized Medical Equipment, Supplies and Assistive Technology – Peri wash, Attend Wash clothes, Diapers, the cap of 28 hours per week of Personal Care 2, the cap of 68 units per month of Respite with exception granting him an additional 33 units per month for a total of 101 units of Respite per month and 24 units per week of Personal Care 1, and I so find (See, Case File);

13. Under the renewal of the MR/RD Waiver on January 1, 2010, Physical Therapy and Daily Respite were terminated, and I so find (See, Case File);

14. Under the renewal of the MR/RD Waiver on January 1, 2010, Occupational Therapy, Speech Therapy and Augmented Communications evaluation and equipment are services that were terminated. There is no evidence to support Petitioner was receiving or denied these services prior to implementation of renewal of MR/RD waiver on January 1, 2010, and I so find (See, Case File);

15. The only jurisdictional issue in this matter is whether SCDHHS by its agent, SCDDSN, has the authority to develop and determine policies and procedures for the implementation of Medicaid programs and services, and to alter or amend those policies and procedures as may be necessary as provided for under applicable Federal Law and Regulations, and I so find;

16. Petitioner asserts the Office of Hearings and Appeals is prohibited from dismissing Petitioner's appeal without a hearing because Regulation 126-154 exceeds the authority granted to the tribunal under 42 U.S.C.§ 1396(a)(3) Title 42 of the Code of Federal Regulations (CFR), which require "SCDDSN" to provide Petitioner with a fair hearing where he is entitled to present witnesses and evidence and to cross examine the witnesses of the Respondent without administrative delay, and I so find;

17. Petitioner asserts the Petitioner is entitled to a fair hearing complying with regulations contained in Title 42 CFR and to attempt to deny this right to the Petitioner to present his case before an unbiased tribunal and to make a decision solely on evidence presented at the hearing is an error in law, and I so find;

18. Petitioner's reliance on 42 CFR 431.220 is misplaced in that the regulations specify when the "opportunity" for a hearing must be afforded. "The agency must grant an opportunity for a hearing for a number of reasons, including for any recipient who requests one because he or she believes the agency has taken an action erroneously." §431.220 (a) (2).

However, "[t]he 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." §432.220(b) Petitioner failed to set forth a "cause of action" as mandated by Rule 8, General Rules of Pleading of the South Carolina Rules of Civil Procedures for which relief could be granted, and I so find;

19. SCDHHS regulations on Appeals and Hearings §126-154 states: "A Hearing Officer has the authority, among other things, to: direct all procedures; issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or conclusions of law; call witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with the requirements of the subarticle", and I so find;

20. Petitioner asserts Respondent has violated Petitioner's due process rights by failing to maintain and provide a fair hearing system as required by 42 U. S. C. § 1396(a)(3) and applicable regulations and *Goldberg v. Kelly,* which provide an opportunity to be heard before an unbiased tribunal and providing a notice identifying the statues or regulations which support the action taken by SCDDSN and dismissal of Petitioner's appeal would violate his statutory rights, in addition to his rights under the Fourteenth Amendment of the United States Constitution, and I so find;

21. In Goldberg, the Court did not reach the issue of whether an opportunity for both written and oral argument must be afforded. Thus the Court left open the possibility than only an opportunity for a written argument is minimally required. See Goldberg, 397 U.S. at 268n. 15. As cited in Rosen v Goetz 410 R. 3d 919 (6th Cir. 2005). Furthermore, it has been established that "[d]ue process is flexible and calls for such procedural protections the particular situation demands." Mathews v. Eldridge, 424 U.S. 319 (1976). The requirements of due process, as outlined in Goldberg and Mathews have been met, and I so find;

22. In the case of Mims v. SCDHHS, Docket No. 08-ALJ-08-0082-AP (Adm. Law Crt. 2007), the Administrative Law Court discussed the limitations imposed on SCDHHS Hearing Officers imposed by the Fair Hearing regulations at 42 CFR §431.223. The court acknowledged that those regulations provide situations in which the Hearing Officer may dismiss appeals: 1) withdrawals by the Petitioner and 2) failures to appear. However, in the case of Sunset Cay, LLC v. City of Folly Beach, 357 S.C. 414, 593 S.E.2d 462 (2004), the court found that the word "may" was permissive and not mandatory. Further the federal regulation was not so comprehensive that the SCDHHS State hearing regulations, which allowed for greater discretion of the Hearing Officers to dismiss appeals, could not be given effect, and I so find;

23. Petitioner asserts that any authority the Respondent has to develop and determine policies and procedures for the establishment and implementation of Medicaid programs are preempted by § 1396 et seq. of the Social Security Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act and the American Recovery and Rehabilitation Act (ARRA). Petitioner argues that the reduction of Petitioner's Waiver services through reduction of Personal Care II hours and failure to authorize the

maximum respite hours was arbitrary and not based on medical necessity or any determination by Petitioner's treating physician which is in violation of these federal laws and Supremacy Clause of the United States Constitution, and I so find;

24. Each state is responsible for the operation of its Medicaid program while CMS is the federal agency charged with administrative oversight of all Medicaid programs. In this capacity, CMS promulgates regulations, develops policy, and guides states in the operation of their Medicaid programs. CMS also must approve each state plan, all state applications for Medicaid waivers, and any amendments to either the plan or to waiver programs, and I so find;

25. Olmstead allows for States to take into account the resources available to the State and the needs of others with disabilities in their responsibility to provide community-based treatment for persons with mental disabilities. Olmstead states the State's responsibility "is not boundless" which acknowledges 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. In order to equitably apportion services to the population of persons with mental disabilities, the Agency must be allowed to reasonably limit otherwise "boundless" services, and I so find;

26. The restrictions of the ARRA enacted by Congress on February 17, 2009 states in order to receive enhanced FMAP, a state may not restrict eligibility "standards, methodologies, or procedures" beyond those in effect on July 1, 2008. South Carolina's Medicaid Waiver program that went into effect on January 1, 2010 clearly places limitations on services that are the subject of this action and does not restrict eligibility, and I so find;

27. Petitioner asserts Respondent's decision to reduce Petitioner's waiver services was arbitrary and was not based on medical necessity or any determination by Petitioner's treating physician, which violates the Medicaid Act, the ADA and Section 504 ARRA, and I so find;

28. Refer to Findings of Fact #24, #25 and #26, and I so find;

29. Petitioner asserts Respondent has violated Petitioner's rights under the ARRA by diverting funds Congress intended to be used to maintain services to Petitioner and to preserve the job of his caregiver, and I so find;

30. Refer to Findings of Fact #26, and I so find;

31. Petitioner asserts Respondent has violated South Carolina Code of Laws §44-6-70(b), §44-6-70(f), §44-6-40, §44-6-70, §44-6-80 and §44-6-132, and I so find;

32. S.C. Code of Law §44-6-40 describes the duties of the Department as to administer the federal plans under its control guided by the goal of "...administering the plans in the most effective and efficient way possible", and I so find;

33. S.C. Code of Law §44-6-70 directs the Department to ".... maximize utilization of private and nonprofit providers...", and I so find;

34. S.C. Code of Law §44-6-80 requires the Department to submit an annual report, and I so find;

35. S.C. Code of Law §44-6-132 sets forth the legislative findings and intent with respect to the Medically Indigent Assistance Program, which generates state tax funds to use as match funds under the Medicaid Program and is also operated outside of the Medicaid Program. The funds generated are supplementary to general appropriations and are distributed in accordance with §44-6-155. The Medically Indigent Assistance Program has not been affected by the Waiver renewal, and I so find;

36. Petitioner failed to prove Respondent has violated its enabling legislation through violation of S.C. Code of Laws §44-6-40, §44-6-70, §44-6-80 and §44-6-132. Respondent, due to the State of South Carolina's budget situation, employed reasonable standards in setting limits in the Waiver renewal efficiently with the use of private providers specified in the Waiver, submission of required annual report and without affecting the Medically Indigent Assistance Program, and I so find;

37. Petitioner asserts misuse of State funds by the Respondent and Respondent's Agent (DDSN), and I so find (See Petitioner's response to Interlocutory Order under #7, #8, #9, #10, 17 and 19# in file);

38. Assertion of misuse of State funds raised in a Petition for the South Carolina Supreme Court to take original jurisdiction and grant an injunction against the Departments' imposition of the Waiver limitations that were going into effect on January 1, 2010 was denied by the Supreme Court allowing the Waiver limitations to go into effect on January 1, 2010, and I so find;

39. Petitioner asserts inadequate notice of elimination of waiver services to the MR/RD Medicaid Waiver program to include speech and language services, cost of wheelchairs, physical therapy and occupational therapy with Respondent failing to inform Petitioner of all feasible alternatives under the MR/RD Medicaid waiver which would allow him to remain in the least restrictive setting, including but not limited to assistive communications equipment, adult companion services, PCA 1 services, psychological and nursing services, and I so find;

40. In September 2009 and October 2009, six (6) statewide workshops were held alerting the public of the proposed changes to the Waiver. A general notice was sent to all SCDDSN clients on December 1, 2009 notifying them of the pending changes approved by CMS in November 2009. Notice urged clients to work closely with their DDSN Service Coordinators to mediate the impact of the new service limits. Notices were sent to clients directly impacted by the new service limits later in December 2009, and I so find;

41. Petitioner has been given two opportunities and has failed to state a legitimate error of fact/law or cause of action concerning the issue in this matter, whether the Respondent by its agent, DDSN, has the authority to develop and determine policies and procedures for the implementation of Medicaid programs and services, and to alter or amend those policies and procedures as may be necessary as provided for under applicable Federal Law and Regulations, for which the Hearing Officer can grant relief, and I so find.

CONCLUSIONS OF LAW

Based upon the above Findings of Fact, I conclude the following as a matter of law:

In accordance with SCDHHS regulations 126-154, the Petitioner has failed to respond to Hearing Officer's Interlocutory Order with an allegation of error in fact or in law as ordered, and the matter is therefore subject to dismissal.

DECISION

Based on the Findings of Fact and Conclusions of Law, this matter is **DISMISSED**.

AND IT IS SO ORDERED.

Janet R. Goode
Hearing Officer

DATED AT COLUMBIA,
South Carolina

May 6, 2010

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

February 25, 2010

1ST CLASS REGULAR MAIL AND CERTIFIED MAIL

Carolyn C. Myers
106 Hunt Cup Lane
Camden, SC 29020

RE: Appeal Request in the Matter of Albert Cooper Myers v. SCDHHS
Appeals Case #10-MISC-040 (MR/RD)

INTERLOCUTORY ORDER
(CAUSE OF ACTION)

Dear Ms. Myers:

This is an Interlocutory Order issued pursuant to SCDHHS Regulation 126-154. Please read carefully, as you must file a response as directed by a date certain: **March 15, 2010**.

I am in receipt of your appeal request concerning the decision by the Department of Disabilities and Special Needs (DDSN) to decrease services provided to Albert Cooper Myers under the Mental Retardation and Related Disabilities (MR/RD) Waiver Program. I am also in receipt of Dr. Buscemi's letter explaining the reasons for the changes in DDSN Waiver Services and Programs in general, which have been imposed as a consequence of substantial reductions in State budget appropriations for the agency. As is stated in Dr. Buscemi's letter, these changes were reviewed and approved in advance by the Federal Agency (Centers for Medicare and Medicaid Services) which oversees State Medicaid Programs that receive matching Federal funds. The Federal Government recognizes the South Carolina Department of Health and Human Services (DHHS) as the single State agency administering, or supervising the administration of Medicaid programs and services in South Carolina (Title 42 Code of Federal Regulations 400.203). As provided for under applicable Federal Law and Regulations, the State Medicaid Agency has the authority to develop and determine policies and procedures for the establishment and implementation of Medicaid programs and services, and to alter or amend those policies and procedures as may be necessary.

Division of Hearings and Appeals
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2600 • Fax (803) 255-8206

In addition, I am in receipt of correspondence from Jacob Chorey, MR/RD Waiver Program Coordination, DDSN that shows Albert Cooper Myers' complete, authorized service package prior to the renewal of the MR/RD Waiver on January 1, 2010 with service modifications that comply with terms of the renewed waiver. Mr. Chorey states the only changes to Mr. Myers' service package are the termination of Physical Therapy and Daily Respite which are services that were eliminated from the waiver, reduction of Personal Care II hours of 45 per week to the cap of 28 hours per week per renewal of the waiver, increase of hourly Respite to the cap of 68 per month per renewal of the waiver from previous 38 per month with the exception taken into consider granting him 33 additional units per month and addition of 24 units per week of Personal Care I. Appeal of services not being received by Mr. Myers' prior to the renewal of the MR/RD Waiver on January 1, 2010 (Speech Therapy, Occupational Therapy and denial of coverage for Augmented Communications evaluation and equipment stated by you in your appeal request) are not appealable issues unless you can submit an error by the Agency that these services were being received prior to the renewal of the Waiver and are now terminated.

The purpose of an appeal is to give you the opportunity to present evidence that the Department has made an error in its decision. A Hearing Officer cannot alter, amend, or set aside established Medicaid policy, unless you can present evidence of an error, (such as, the programmatic changes are in violation of Federal or State laws or regulations governing the administration of Medicaid services.)

If you believe an error has been made in the determination of Albert Cooper Myers' eligibility for Medicaid benefits, **you must state the error in writing,** and I must receive it by a date certain: **March 15, 2010**. Otherwise, I will assume you do not wish to go forward with the appeal and it will be dismissed.

If you have any questions about this correspondence, please contact me at (803) 898-2600, or 1-800-763-9087.

Sincerely,

Janet R Goode

Janet R Goode, Hearing Officer
Division of Appeals and Hearings

- 5 units per week of Day Activity (unchanged)
- Specialized Medical Equipment, Supplies and Assistive Technology – Peri was 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 fo 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)

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF HEARINGS AND APPEALS

Albert Cooper Myers,
Appellant

v.

South Carolina Department of Health and Human Services

Appeals Case #10-MISC-040 (MR/RD)

REPLY TO INTERLOCUTORY ORDER

In response to the Interlocutory Order issued by the hearing officer dated February 25, 2010, Appellant responds as follows:

1. The Office on Hearings and Appeals is prohibited from dismissing Appellant's appeal without a hearing because Regulation 126-154 exceeds the authority granted to the tribunal under 42 U.S.C. § 1396a(a)(3) Title 42 of the Code of Federal Regulations, which require SCDDSN to provide Appellant with a fair hearing where he is entitled to present witnesses and evidence and to cross examine the witnesses of the Respondent without administrative delay.

2. Respondent has violated Appellant's due process rights by failing to maintain and provide a fair hearing system as required by 42 U.S.C. § 1396a(a)(3) and applicable regulations and *Goldberg v. Kelly*, which provide an opportunity to be heard before an unbiased tribunal and providing a notice identifying the statutes or regulations which support the action taken by SCDDSN and dismissal of Appellant's appeal would violate his statutory rights, in addition to his rights under the Fourteenth Amendment of the United States Constitution and the Supremacy Clause of the United States Constitution..

3. Any authority the Respondent (SCDHHS) has to develop and determine policies and procedures for the establishment and implementation of Medicaid programs are preempted by § 1396 et seq. of the Social Security Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act (Section 504) and the American Recovery and Rehabilitation Act (ARRA) and the actions taken by Respondent have violated these federal laws and the Supremacy Clause of the United States Constitution.

4. Respondent has violated Appellant's rights under the American Recovery and Reinvestment Act by diverting funds Congress intended to be used to maintain services to Appellant and to preserve the job of his caregiver.

5. Respondent has violated South Carolina Code of Laws § 44-6-70(b), which requires SCDHHS to provide the most appropriate care, tailored to the client's needs and delivered in the most cost effective manner.

6. Respondent has violated South Carolina Code of Laws § 44-6-70(f), which requires SCDHHS to assure the maximum utilization of private and non-profit providers in administration and service delivery systems by approving changes to the MR/RD Medicaid waiver based on a pretext of budget reductions when the purpose of the amendments was to eliminate services provided by private providers while maintaining band payments to local DSN Boards. These changes will result in increased costs to taxpayers and they are intended to limit services being provided by private and faith-based providers.

7. Director Forkner and Governor Sanford have been placed on notice by one or more SCDDSN Commissioners and the former internal auditor of SCDDSN about the misuse of funds by SCDDSN which were intended to provide services and they have ignored these reports and failed to take appropriate action to hold SCDDSN accountable for the expenditure of Medicaid funds in violation of the Medicaid Act, resulting in fewer dollars being available to provide home-based services to Appellant and other waiver participants.

8. Funds allocated by the state and federal governments to provide services have instead been used to pay for vacant beds and to purchase real estate which has been used to provide congregate services where people like Appellant are segregated from the community, thus reducing funds available to provide services to Appellant in his home.

9. Respondents have encouraged the monopoly of DSN Boards, in violation of state and federal laws, thereby reducing the choice of providers available to Appellant, in an attempt to force Appellant into institutional day or residential services provided by SCDDSN and its DSN Boards, at a greater cost to the taxpayer.

10. The actions taken by Respondent and its officials place Appellant's health and welfare at risk, in violation of the assurances provided to CMS pursuant to the Medicaid Act, including the requirements that Respondent protect the health and welfare of Appellant and that Respondent provide waiver services in the amount, duration and scope necessary to comply with the purpose of the home and community based waiver program, i.e. to prevent or delay the institutionalization of Albert Cooper Myers.

11. The State has determined that Albert Cooper Myers' needs may be met by providing services in the community, he does not oppose receiving services in the community and these services will be provided, at a lesser cost to the State, by maintaining the services provided prior to January 1, 2010.

12. The reduction of Appellant's PCA hours and the failure to authorize the maximum respite hours violate the ADA, Section 504 of the Rehabilitation Act and ARRA.

13. Appellant was adversely affected by the elimination of speech and language services from the MR/RD Medicaid waiver program, which are needed to assess choking risks and his need for assistive communications equipment, however, Appellant did not receive notice of the termination of this service which met applicable regulatory standards of the elimination of this waiver service.

14. Appellant is adversely affected by and Respondent failed to provide adequate notice of the limitation on the cost of wheelchairs provided by the MR/RD Medicaid waiver.

15. Appellant was adversely affected by the elimination of physical therapy and occupational therapy services, but Appellant did not receive notice meeting the applicable regulatory standards prior to the elimination of these waiver services from the MR/RD Medicaid waiver program.

16. The decision to reduce Appellant's waiver services was arbitrary and was not based on medical necessity or any determination by Appellant's treating physician, which violates the Medicaid Act, the ADA and Section 504.

17. The decision by SCDHHS to reduce waiver services while increasing institutional respite reimbursement rates by 70% was not based on reasonable standards, as is required by the Medicaid Act, and was not in the best interest of the participants, another requisite of the Medicaid Act.

18. Appellant is entitled to a fair hearing complying with the regulations contained in Title 42 of the Code of Federal Regulations and it is an error of law to attempt to deny this right to present his case before an unbiased tribunal and to make a decision solely on evidence presented at the hearing.

19. Funds were and continue to be available to provide the services and supports which Appellant requests.

20. SCDDSN and SCDHHS have failed to inform Appellant of all feasible alternatives under the MR/RD Medicaid waiver which would allow him to remain in the least restrictive setting, including but not limited to asssitive communications equipment, adult companion services, PCA I services, psychological services and nursing services.

21. Respondent has violated S.C. Code of Laws § 44-6-40, which requires SCDHHS to deliver services and to administer plans in the most effective and efficient ways possible and to inform the South Carolina General Assembly prior to making substantial changes to the MR/RD Medicaid waiver program.

22. Respondent has violated S.C. Code of Laws § 44-6-70 which requires SCDDSN to maximize utilization of private and nonprofit providers in administration and service delivery systems, instead, allowing SCDDSN to use scarce resources to purchase real estate to continue barriers to competition which were identified in the 2008 audit by the South Carolina Legislative Council.

23. Respondent violated South Carolina Code of Laws § 44-6-80 by failing to advise the General Assembly of substantive issues related to changes in the MR/RD Medicaid waiver program.

24. Respondent violated South Carolina Code of Laws § 44-6-132 by failing to use state funds to take advantage of federal funds, instead using funds allocated by the General Assembly and client fees to purchase real estate for DSN Boards which compete with private providers.

Now, therefore, Appellant requests an order:

(1) Scheduling a hearing on this matter in which SCDHHS addresses each and every error described herein, as well as the termination, reduction or suspension of MR/RD Medicaid waiver services.

(2) Requiring Respondent and SCDDSN to make available for review by Appellant all documents in the possession, custody or control of the Office of the Governor, SCDHHS, SCDDSN and the State Budget and Control Board and its members and staff, information related to (a) Albert Cooper Myers and (b) the reduction of MR/RD Medicaid waiver services and communications with CMS related to the amendments to the MR/RD Medicaid waiver.

(3) Appellant requests an order finding that the changes in services provided to Albert Cooper Myers were not based on federal or state law requiring an automatic change adversely affecting some or all recipients. 42 C.F.R. 431.220(b).

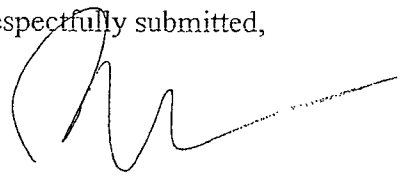
(4) Appellant requests an order finding that the changes were based on actions taken by HHS in violation of its statutory and Constitutional obligations to Appellant and were made without authorization by the South Carolina General Assembly.

(5) Appellant requests an order finding that the notice provided by Respondent did not meet the very specific requirements of 42 C.F.R. 431.210.

(6) Appellant requests restatement and continuation of services because action was taken without the advance notice required under § 431.211. 42 C.F.R. § 431.231(c)(1).

(7) The facts related to the errors made by the Respondent and the reductions and terminations of services are in dispute. This tribunal may not dismiss Appellant's request for a fair hearing without providing a hearing.

Respectfully submitted,



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

March 15, 2010

Columbia, South Carolina

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF HEARINGS AND APPEALS

Albert Cooper Myers,
Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent.

Appeals Case #10-MISC-040 (MR/RD)

CERTIFICATE OF FILING AND SERVICE

I, Nancy C. Law, Assistant to Patricia L. Harrison, Attorney for Appellant, certify that I filed one copy of the foregoing Response to Interlocutory Order with the SC Dept. of Health and Human Services, Office of Appeals and Hearings, via fax, on March 15, 2010. I further certify that I have this day, March 16, 2010, served one copy of the Response to Interlocutory Order by US Mail, with sufficient postage attached, on counsel of record:

Richard Hepfer, Esquire
SC Dept of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Nancy C. Law, Assistant to
Patricia L. Harrison

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND	)	BEFORE THE APEALS DIVISION OF THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES
Mr. Albert Cooper Meyers, Petitioner, -v- State Department of Health and Human Services, Respondent.	)	RETURN TO REPLY TO ITERLOCUTORY ORDER 10-MISC-040 (MR/RD)

TO: 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 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 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. 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. The DDSN is responsible for the day-to-day operation of this Waiver. The Department of Health and Human Services (Department, DHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the waiver. This appeal is directly from a DDSN Reconsideration of a reduction in services to the Petitioner. The reduction was the result of the limitations set forth in the renewed Waiver. The Reconsideration upheld the original reduction, thus, this appeal is before the Appeals Division of the DHHS.

Responses to Allegations

The Petitioner first alleges numerous violations of the Fair Hearing regulations at 42 CFR §431.200 et seq. Allegations 1, 2, 18.

The Fair Hearing regulations that govern this matter are set forth at 42 CFR §431.200 et seq. The regulations implement §1902(a)(3) of the Social Security Act [42 USC §1396a(a)(3)] which requires the "...[s]tate to provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly." 42 CFR §431.200(a).

The regulations further prescribe "...procedures for an opportunity for a hearing if the State agency ... takes action to suspend, terminate, or reduce services..." §431.200(b).

"The hearing system must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970), and any additional standards specified in this subpart." §431.205(d).

The agency must grant a hearing for a number of reasons, including for any recipient who requests one because he or she believes the agency has taken an action erroneously. §431.220(a)(2). However, "[t]he 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." §432.220(b).

In Goldberg, the Court did not reach the issue of whether an opportunity for both written and oral argument must be afforded. Thus the Court left open the possibility that only an opportunity for a written argument is minimally required. See Goldberg, 397 U.S. at 268 n. 15. As cited in Rosen v Goetz 410 F. 3d 919 (6th Cir. 2005). Furthermore, it has been established that "[d]ue process is flexible and calls for such procedural protections and the particular situation demands." Mathews v. Eldridge, 424 U. S. 319 (1976).

Rosen involved the Tennessee governor's 2005 decision to eliminate three (3) of the State's seventeen (17) eligibility categories for TennCare, the State's Medicaid demonstration waiver. The State was to mail notices to the recipients that they were being terminated and did not qualify for another category and give them the opportunity to respond with information regarding their current circumstances. Any response that raised a "valid factual dispute" would be scheduled for a hearing, but when responses that were not returned or when the responses raised only challenges to the State's policy judgment, the cases were to be dismissed. The district court had enjoined the agency from proceeding.

The Sixth Circuit reversed agreeing with the State's position that, "...the government need not provide hearings to beneficiaries who have failed to raise a 'valid factual dispute' about their

eligibility for coverage under another Medicaid Program." The circuit court applauded the distinction between impermissible challenges to the State's legal or policy judgment and challenges to facts or applications of the law. The court found that such a distinction respects both §431.220(a)(2), giving recipients the opportunity to challenge erroneous actions and §431.220(b), which says that the State need not have a hearing if the sole issue is one of State or Federal law. Rosen, at 926.

In short, the regretful imposition of limitations in the Waiver services has been carried out with ample notice and opportunity to submit written explanations of errors. The requirements of due process, as outlined in Goldberg and Mathews have been met.

As to the Hearing Officer's authority to dismiss, in the case of Mims v. SCDHHS, Docket No. 07-ALJ-08-0082-AP (Adm. Law Crt. 2007) (attached), the Administrative Law Court discussed the limitations imposed on SCDHHS Hearing Officers imposed by the Fair Hearing regulations at 42 CFR §431.223. The court acknowledged that those regulations provide situations in which the Hearing Officers may dismiss appeals: 1) withdrawals by the Petitioner and 2) failures to appear.

However, Citing Sunset Cay, LLC v. City of Folly Beach, 357 S.C. 414, 593 S.E.2d 462 (2004), the court found that the word "may" was permissive and not mandatory. Further the federal regulation was not so comprehensive that the SCDHHS State hearing regulations, which allowed for greater discretion of the Hearing Officers to dismiss appeals, could not be given effect.

The reductions are violative of the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act and the Supreme Court's holding in and Olmstead v L.C. ex rel. Zimring, 527 U.S. 581 (1999). Allegations 3 (in part), 10, 12 (in part), & 16.

Under Olmstead, 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.

First of all, Olmstead dealt with deinstitutionalization of individuals who wanted to be integrated into community living. The Petitioner in this case is already living in the community. It is speculative at best to assume that this reduction in services will lead to his institutionalization.

However, even if he does, in the future, experience difficulty, "[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 have recently applied for renewal of the MR/RD Waiver, which has been approved by CMS. The DDSN has responsibility for providing services to the developmental disabled population of the State. In order to equitably apportion services, the Department must be allowed to reasonably limit otherwise "boundless" services.

The reductions are violative of the American Recovery and Reinvestment Act. Allegations 3 (in part), 12 (in part) & 17

Congress enacted the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. H.R. 1, 111th Cong., Pub.L. No. 111-5 (1st Sess.2009). Under ARRA, in order to receive enhanced FMAP, a state may not restrict eligibility "standards, methodologies, or procedures" beyond those in effect on July 1, 2008. See, § 5001(f)(1) of ARRA. Gray Panthers of San Francisco v. Schwarzenegger, 2009 WL 2880555, (N.D. Cal. 2009)(emphasis added).

Petitioners apparently claim that the changes set to take effect in South Carolina's Medicaid Waiver program on January 1, 2010, are in violation of Section 5001 of ARRA. However, since it is manifestly the limitations on services that are the subject of this action, the restrictions of ARRA do not apply.

Misuse of State funds. Allegations 7 – 10, 17, & 19

These allegations, as well as those in the previous section, were raised in a Petition for the South Carolina Supreme Court to take original jurisdiction and grant an injunction against the Departments' imposition of the Waiver limitations, which were to go into effect on January 1, 2010. The Petition and request for an injunction were filed on December 30, 2009, and responded to on December 31, 2009 by the Departments. All of the allegations in 4-9 of the Petitioner's Reply to the Interlocutory Order were raised in the Petition to the Supreme Court (attached). In the attached Order, issued on February 4, 2010, the Supreme Court denied the Petition and declined to grant the injunction, thereby allowing the Wavier limitations to go into effect on January 1, 2010.

Inadequate notice. Allegations 13, 14, 15, & 20.

In the case of the SCDDSN reductions, six (6) statewide workshops were held in the September and October preceding the reductions. The workshops were well attended by both advocates and beneficiaries. The purpose of the workshops was to alert the public of the proposed changes. At the time of the workshops, the Waiver application had been sent to CMS (August 31, 2009). In November, the Waiver was approved with no substantive changes in the limits at issue here.

On December 1, 2009, a general notice was sent out to all SCDDSN clients notifying them of the pending changes and urging them to work closely with their SCDDSN Service Coordinators (case managers) to mediate the impact of the new service limits. Later in December, specific notices were sent to the beneficiaries, who were directly impacted. The Notices complied with

the requirements of §431.210. Services continued at the pre-limit levels for those individuals who sought reconsideration within the regulatory ten (10) day period.

Service coordinators affirmatively contacted and are continuing to work with the effected clients in order to help rearrange services to get the most coverage within the new Waiver limits. All clients have the right to Reconsideration by the SCDDSN Director. Those clients dissatisfied with the Director's decision may appeal to the Single State Medicaid Agency, the SCDHHS. In this case, as in all others, individuals who have been appealed to the SCDHHS have been given another opportunity to set forth a valid factual dispute in writing to the Hearing Officer.

Allegations that the SCDHHS has violated its enabling legislation. Allegations 5, 6, & 21-24.

The Petitioner alleges that various sections of SC Code Ann. (of the SDHHS enabling legislation were violated.

§44-6-40 describes the duties of the Department as to administer the federal plans under its control guided by the goal of "...administering the plans in the most effective and efficient way possible."

On page 1 of the Waiver Application the following statement appears:

> 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:

§44-6-70 deals with the preparation of the State Plan and directs the Department to consider the objectives of seeing that "...appropriate care is given, tailored to the client's needs, it is delivered in the most cost-effective manner... and "...maximiz[ing] utilization of private and nonprofit providers...."

Waivers, operate outside the State Plan, but follow general Medicaid rules unless they are "waived." Waivers, by their nature are required to meet cost-effectiveness standards set forth in 42 CFR §441.300 et seq. The required Brief Description of the Waiver at the beginning of the Waiver document includes the following language:

> SCDDSN utilizes an organized health care delivery system that includes both county Disability and Special Need Boards and private providers as waiver service providers.

§44-6-80 requires the Department to submit an annual report.

The Department's annual report can be located at:
http://www.dhhs.state.sc.us/Internet/pdf/annual%20report%20final08.pdf

§44-6-132 sets forth the legislative findings and intent with respect to the Medically Indigent Assistance Program (MIAP).

The MIAP Program is also operated outside of the Medicaid Program, but generates state tax funds to use as match funds under the Medicaid Program. The funds generated are supplementary to general appropriations and are distributed in accordance with §44-6-155.

Therefore, it appears that reasonable standards were employed in specifying the limits set forth in the Waiver renewal. Furthermore, the limitations in the Waiver renewal were an attempt by the State to administer the Programs efficiently, that use of private providers is specified in the Waiver, that the required annual report has been submitted and that the MIAP has not been affected.

Mr. Meyers receives Dental Services, forty-five (45) hours of Personal Care Aide II (PCAII) services per week, thirty-eight (38) hours of Hourly Respite Care per month and four (4) units of Daily Respite per month, Specialized Medical Equipment, Supplies and Assistive Technology, four (4) units per week of Physical Therapy, and five (5) per week each of Community Services and Day Activity. Based on the Waiver limits, Physical Therapy would be terminated, his PCAII services would be reduced to twenty-eight (28) hours per week, his Daily Respite would be terminated, but his Hourly Respite would increase to 101 units per month (this includes a hardship exception of 33 units per month). Furthermore, he would begin to receive 6 hours per day of PCI care. See the DDSN Memo of 24 February 2010.

The Waiver document specifies:

> 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) seasonal 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. Appendix C: Participant Services, C-1/C-3: Service Specifications.

Conclusion

Since the Departments have shown that proper notice and consideration of the reductions were provided and since the Petitioner has, so far, only challenged the policy changes in the Waivers limiting the services, the reductions in this case must be affirmed. However, if he so alleges, the Petitioner should have an opportunity to establish that he meets the criteria for extended Respite Care. Therefore, the Respondents respectfully request that the Hearing Officer inquire in to the matter and issue an Order:

1) Setting a hearing in this matter for the limited purpose of determining whether the Petitioner meets the criteria for more extended Respite Care, if he so alleges;

20 Dismissing the Petitioner's other allegations as failing to state a factual dispute by reason of which, the Hearing Officer could grant relief; and

2) Such other remedies as justice should demand.

Respectfully Submitted,

Richard G. Hepfer
Deputy General Counsel
Office of General Counsel
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Voice: (803) 898-2791
Fax (803) 255-8210
hepfer@scdhhs.gov
Attorney for the Respondent

Columbia, South Carolina
March 30, 2010

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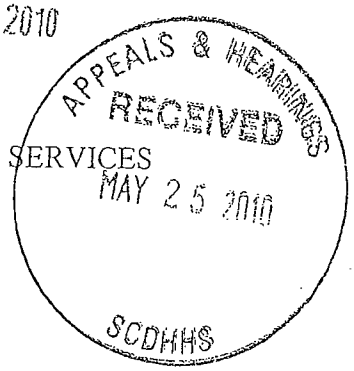


SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF HEARINGS AND APPEALS

Albert Cooper Myers,
Appellant

v.

South Carolina Department of Health and Human Services

Appeals Case #10-MISC-040 (MR/RD)

MOTION TO RECONSIDER

As the Court recognized in *Doe v. Kidd*, where a state fails to provide a Medicaid recipient with adequate pre-deprivation due process in the form of a fair hearing, then a 42 U.S.C. Section 1983 action could be brought against the state, because of the Fourteenth Amendment would supply the right in these circumstances." *Doe v. Kidd* at fn 6. Albert Cooper Myers requests reconsideration of this Court's order denying his right to a fair hearing prior to filing an action in federal court. Myers asks that the hearing officer reconsider and rule upon the following issues:

1. The Office on Hearings and Appeals is prohibited from dismissing Appellant's appeal without a hearing because Regulation 126-154 exceeds the authority granted to the tribunal under 42 U.S.C. § 1396a(a)(3) Title 42 of the Code of Federal Regulations, which require SCDDSN to provide Appellant with a fair hearing where he is entitled to present witnesses and evidence and to cross examine the witnesses of the Respondent without administrative delay.

2. Respondent has violated Appellant's due process rights by failing to maintain and provide a fair hearing system as required by 42 U.S.C. § 1396a(a)(3) and applicable regulations and *Goldberg v. Kelly*, which provide an opportunity to be heard before an unbiased tribunal and providing a notice identifying the statutes or regulations which support the action taken by SCDDSN and dismissal of Appellant's appeal would violate his statutory rights, in addition to his rights under the Fourteenth Amendment of the United States Constitution and the Supremacy Clause of the United States Constitution..

3. Any authority the Respondent (SCDHHS) has to develop and determine policies and procedures for the establishment and implementation of Medicaid programs are

preempted by § 1396 et seq. of the Social Security Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act (Section 504) and the American Recovery and Rehabilitation Act (ARRA) and the actions taken by Respondent have violated these federal laws and the Supremacy Clause of the United States Constitution.

4. Respondent has violated Appellant's rights under the American Recovery and Reinvestment Act by diverting funds Congress intended to be used to maintain services to Appellant and to preserve the job of his caregiver.

5. Respondent has violated South Carolina Code of Laws § 44-6-70(b), which requires SCDHHS to provide the most appropriate care, tailored to the client's needs and delivered in the most cost effective manner.

6. Respondent has violated South Carolina Code of Laws § 44-6-70(f), which requires SCDHHS to assure the maximum utilization of private and non-profit providers in administration and service delivery systems by approving changes to the MR/RD Medicaid waiver based on a pretext of budget reductions when the purpose of the amendments was to eliminate services provided by private providers while maintaining band payments to local DSN Boards. These changes will result in increased costs to taxpayers and they are intended to limit services being provided by private and faith-based providers.

7. Director Forkner and Governor Sanford have been placed on notice by one or more SCDDSN Commissioners and the former internal auditor of SCDDSN about the misuse of funds by SCDDSN which were intended to provide services and they have ignored these reports and failed to take appropriate action to hold SCDDSN accountable for the expenditure of Medicaid funds in violation of the Medicaid Act, resulting in fewer dollars being available to provide home-based services to Appellant and other waiver participants.

8. Funds allocated by the state and federal governments to provide services have instead been used to pay for vacant beds and to purchase real estate which has been used to provide congregate services where people like Appellant are segregated from the community, thus reducing funds available to provide services to Appellant in his home.

9. Respondents have encouraged the monopoly of DSN Boards, in violation of state and federal laws, thereby reducing the choice of providers available to Appellant, in an attempt to force Appellant into institutional day or residential services provided by SCDDSN and its DSN Boards, at a greater cost to the taxpayer.

10. The actions taken by Respondent and its officials place Appellant's health and welfare at risk, in violation of the assurances provided to CMS pursuant to the Medicaid Act, including the requirements that Respondent protect the health and welfare of Appellant

and that Respondent provide waiver services in the amount, duration and scope necessary to comply with the purpose of the home and community based waiver program, i.e. to prevent or delay the institutionalization of Albert Cooper Myers.

11. The State has determined that Albert Cooper Myers' needs may be met by providing services in the community, he does not oppose receiving services in the community and these services will be provided, at a lesser cost to the State, by maintaining the services provided prior to January 1, 2010.

12. The reduction of Appellant's PCA hours and the failure to authorize the maximum respite hours violate the ADA, Section 504 of the Rehabilitation Act and ARRA.

13. Appellant was adversely affected by the elimination of speech and language services from the MR/RD Medicaid waiver program, which are needed to assess choking risks and his need for assistive communications equipment, however, Appellant did not receive notice of the termination of this service which met applicable regulatory standards of the elimination of this waiver service.

14. Appellant is adversely affected by and Respondent failed to provide adequate notice of the limitation on the cost of wheelchairs provided by the MR/RD Medicaid waiver.

15. Appellant was adversely affected by the elimination of physical therapy and occupational therapy services, but Appellant did not receive notice meeting the applicable regulatory standards prior to the elimination of these waiver services from the MR/RD Medicaid waiver program.

16. The decision to reduce Appellant's waiver services was arbitrary and was not based on medical necessity or any determination by Appellant's treating physician, which violates the Medicaid Act, the ADA and Section 504.

17. The decision by SCDHHS to reduce waiver services while increasing institutional respite reimbursement rates by 70% was not based on reasonable standards, as is required by the Medicaid Act, and was not in the best interest of the participants, another requisite of the Medicaid Act.

18. Appellant is entitled to a fair hearing complying with the regulations contained in Title 42 of the Code of Federal Regulations and it is an error of law to attempt to deny this right to present his case before an unbiased tribunal and to make a decision solely on evidence presented at the hearing.

19. Funds were and continue to be available to provide the services and supports which Appellant requests.

20. SCDDSN and SCDHHS have failed to inform Appellant of all feasible alternatives under the MR/RD Medicaid waiver which would allow him to remain in the least restrictive setting, including but not limited to asssitive communications equipment, adult companion services, PCA I services, psychological services and nursing services.

21. Respondent has violated S.C. Code of Laws § 44-6-40, which requires SCDHHS to deliver services and to administer plans in the most effective and efficient ways possible and to inform the South Carolina General Assembly prior to making substantial changes to the MR/RD Medicaid waiver program.

22. Respondent has violated S.C. Code of Laws § 44-6-70 which requires SCDDSN to maximize utilization of private and nonprofit providers in administration and service delivery systems, instead, allowing SCDDSN to use scarce resources to purchase real estate to continue barriers to competition which were identified in the 2008 audit by the South Carolina Legislative Council.

23. Respondent violated South Carolina Code of Laws § 44-6-80 by failing to advise the General Assembly of substantive issues related to changes in the MR/RD Medicaid waiver program.

24. Respondent violated South Carolina Code of Laws § 44-6-132 by failing to use state funds to take advantage of federal funds, instead using funds allocated by the General Assembly and client fees to purchase real estate for DSN Boards which compete with private providers.

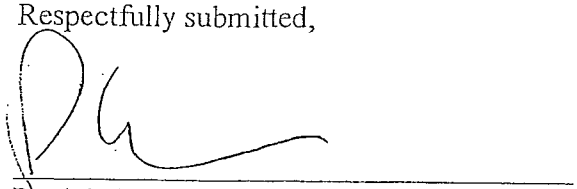
Now, therefore, Appellant requests an order:

(1) Scheduling a hearing on this matter in which SCDHHS addresses each and every error described herein, as well as the termination, reduction or suspension of MR/RD Medicaid waiver services.

(2) Appellant requests restatement and continuation of services because action was taken without the advance notice required under § 431.211. 42 C.F.R. § 431.231(c)(1).

(3) The facts related to the errors made by the Respondent and the reductions and terminations of services are in dispute. This tribunal may not dismiss Appellant's request for a fair hearing without providing a hearing.

Respectfully submitted,



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

May 21, 2010

Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 10-ALJ-08-0504-AP

Albert Cooper Myers,.....Appellant,

v.

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

APPELLANT'S MOTION FOR EXTENSION OF TIME
AND
CONSOLIDATION

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

ATTORNEY FOR APPELLANT

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 10-ALJ-08-0503-AP

Michelle Morgan,.....Appellant,

v.

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

APPELLANT'S MOTION FOR EXTENSION OF TIME
AND
CONSOLIDATION

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

ATTORNEY FOR APPELLANT

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 10-ALJ-08-0503-AP

Michelle Morgan,.....Appellant,

v.

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

CERTIFICATE OF FILING AND SERVICE

I, Patricia L. Harrison, Attorney for Appellant, certify that I have this day, September 13, 2010 filed one copy of the foregoing Motion for Extension and Consolidation with the S.C. Administrative Law Court by mailing same in the US Mail with sufficient first-class postage thereon. I further certify that I have also this day served one copy of the foregoing Motion for Extension and Consolidation upon Respondent by mailing same in the US Mail to their counsel of record with sufficient first-class postage thereon:

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

Patricia L. Harrison

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 10-ALJ-08-0502-AP

Jimmy W. Eubanks, Jr,
.....Appellant,

v.

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

APPELLANT'S MOTION FOR EXTENSION OF TIME
AND
CONSOLIDATION

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

ATTORNEY FOR APPELLANT

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 10-ALJ-08-0502-AP

Jimmy W. Eubanks, Jr,
.....Appellant,

v.

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

CERTIFICATE OF FILING AND SERVICE

I, Patricia L. Harrison, Attorney for Appellant, certify that I have this day, September 13, 2010 filed one copy of the foregoing Motion for Extension and Consolidation with the S.C. Administrative Law Court by mailing same in the US Mail with sufficient first-class postage thereon. I further certify that I have also this day served one copy of the foregoing Motion for Extension and Consolidation upon Respondent by mailing same in the US Mail to their counsel of record with sufficient first-class postage thereon:

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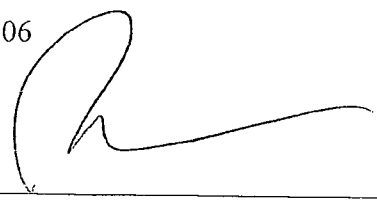

Patricia L. Harrison

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 10-ALJ-08-0504-AP

Albert Cooper Myers,.....Appellant,

v.

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

CERTIFICATE OF FILING AND SERVICE

I, Patricia L. Harrison, Attorney for Appellant, certify that I have this day, September 13, 2010 filed one copy of the foregoing Motion for Extension and Consolidation with the S.C. Administrative Law Court by mailing same in the US Mail with sufficient first-class postage thereon. I further certify that I have also this day served one copy of the foregoing Motion for Extension and Consolidation upon Respondent by mailing same in the US Mail to their counsel of record with sufficient first-class postage thereon:

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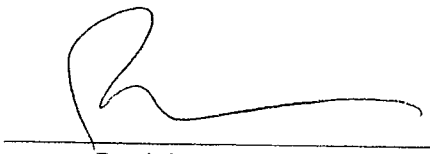


Patricia L. Harrison

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 10-ALJ-08-0501-AP

Susan Edge, ...Appellant,

v.

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

APPELLANT'S MOTION FOR EXTENSION OF TIME
AND
CONSOLIDATION

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

ATTORNEY FOR APPELLANT

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 10-ALJ-08-0501-AP

Susan Edge, ...Appellant,

v.

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

CERTIFICATE OF FILING AND SERVICE

I, Patricia L. Harrison, Attorney for Appellant, certify that I have this day, September 13, 2010 filed one copy of the foregoing Motion for Extension and Consolidation with the S.C. Administrative Law Court by mailing same in the US Mail with sufficient first-class postage thereon. I further certify that I have also this day served one copy of the foregoing Motion for Extension and Consolidation upon Respondent by mailing same in the US Mail to their counsel of record with sufficient first-class postage thereon:

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

Patricia L. Harrison

Undersigned counsel represents Jimmy "Chip" Eubanks, Michelle Morgan, Susan Edge and Albert C. Myers (hereinafter referred to as "Appellants") in their appeals from orders dismissing their requests for fair hearings by hearing officers at the South Carolina Department of Health and Human Services. All of these cases arise out of the same question of law and facts involving reductions in Medicaid services due to an amendment to the MR/RD Medicaid waiver program which went into effect on January 1, 2010. Appellants request that their cases be consolidated and that an extension of time to file briefs be granted for the reasons set forth below.

While preparing Appellants' briefs, counsel discovered that the Record on Appeal is incomplete. All of the Appellants filed requests for reconsideration, but these documents are not contained in the Record on Appeal. An extension is requested because the Record on Appeal in these cases is incomplete. All of these Appellants filed motions for reconsideration at the DHHS Office on Appeals and Hearings when the DHHS hearing officers dismissed their cases. The hearing officer issued a denial of the motion to reconsider in the appeal of Jimmy "Chip" Eubanks on May 24, 2010, but this order and the motion to reconsider are not contained in the Record on Appeal. The other three Appellants filed motions to reconsider, but these motions do not appear to be contained in the Record on Appeal and it does not appear that a final order has been issued in those cases, although 42 C.F.R. § 431.244(f)(1) requires a final order to be issued within 90 days of the request for a fair hearing.

All of the appellants have profound disabilities and elimination of Medicaid waiver services places them in immediate jeopardy of institutionalization. Jimmy "Chip" Eubanks

has severe cerebral palsy and is totally unable to move his legs or arms. He is mentally competent, but is dependent upon others for every activity of daily living because he is unable to get into or out of the bed without assistance and requires hands-on assistance throughout the day to bathe, go to the bathroom, dress, eat, take medications and attend medical appointments. Exhibit 1. (Jimmy "Chip" Eubanks). Chip's mother, who had been his primary caregiver, died in June. Michelle Morgan and Albert C. Myers have severe disabilities and require feeding through a gastronomy tube and they are nonverbal. Exhibits 2 and 3. Susan Edge has profound mental retardation, cerebral palsy, lupus, immune deficiency, seizures, severe osteoporosis and hydrocephalia. She is unable to walk and is nonverbal. DDSN reduced the number of cases of nutritional supplements her physicians have ordered by 20% effective January 1, 2010, but these supplies are being provided pending this appeal. Exhibit 4. All of the Appellants require around-the-clock supervision and assistance with every activity of daily living. Their parents are elderly and have suffered from their own health problems since DDSN announced its intention to reduce home-based services.

Jimmy "Chip" Eubanks and Michelle Morgan are plaintiffs in a civil rights lawsuit filed in the federal district court alleging violations of the Medicaid Act, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. Respondent informed the federal court that it should dismiss their requests for injunctive relief because they had failed to exhaust administrative appeals in the State Administrative Law Court, yet the DHHS hearing officer dismissed their appeals claiming that they have no right to a fair hearing. When waiver participants filed a request asking the South Carolina Supreme Court to hear their objections to the January 1, 2010 reductions in its original jurisdiction in December 2009,

Respondent replied that Appellants must first exhaust administrative remedies, yet Respondent has refused to provide fair hearings meeting the requirements of the Medicaid Act.

The South Carolina Rules of Civil Procedure and the South Carolina Appellate Court Rules may, in the discretion of the presiding administrative law judge, be applied in proceedings before the Court to resolve questions not addressed by the Rules of the Administrative Law Court. Rule 214 of the South Carolina Appellate Court Rules authorizes appellate courts in this State to order the appeal of two or more cases to be consolidated where the same question is involved. Consolidation of these cases would promote judicial economy and would reduce the costs of this litigation.

Because all of these cases involve dismissal of Medicaid fair hearing proceedings by DHHS hearing officers without providing an evidentiary hearing, which Appellants allege violated their due process rights, Appellants request consolidation. Appellants allege irregularities in procedure before the agency which are not shown in the record and intend to request that the case be remanded to the agency for such action as the court considers appropriate. South Carolina Code of Laws § 1-23-380(4). Since they were not provided the opportunity to create a record or to present witnesses or cross examine Respondent's witnesses, Appellants intend to present additional evidence requesting that this Court issue an order that the additional evidence be taken before the agency upon conditions determined by the court. South Carolina Code of Laws § 1-23-380(3).

Petitioner respectfully requests an extension of time to file briefs and that the Court order a status hearing to discuss a scheduling order and consolidation of these appeals.

Respectfully sutmitted,

Patricia L. Harrison
611 Holly Street
Columbia, South Carolina 29205

(803) 256 2017
plh.cola@att.net

Attorney for Jimmy "Chip" Eubanks, Michelle Morgan, C. Albert Myers and Susan Edge

September 13, 2010

Columbia, South Carolina

Exhibit 1

Documents Related to Jimmy "Chip" Eubanks

STATE OF SOUTH CAROLINA)
) AFFIDAVIT OF CHIP EUBANKS
COUNTY OF LAURENS)
)

1. My mother went into Greenville Hospital on Wednesday, June 16 and she passed away on Saturday, June 19, 2010.

2. I have lived at home all my life and my mother was my caregiver until she became too sick to take care of me, but now I do not have a family member who is willing and able to take care of me.

3. My mother was diagnosed with kidney failure on or about May 19, 2010 and I requested that DDSN provide additional PCA hours through my attorney.

4. My attorney arranged for a meeting with my service coordinator at the Laurens DSN Board on May 21, 2010 in the afternoon and she asked to participate by phone.

5. Instead, without contacting my attorney, two employees from the Laurens DSN Board came out to my house on the morning of May 21, 2010 and told me that they were increasing my respite hours to 112 a month from 68 per month because of the recent deterioration in my mother's condition.

6. I later learned that Dr. Kathi Lacy, Associate Deputy Director of DDSN, had provided the Court a sworn statement on May 17, 2010 saying that I have been receiving 112 hours of respite services a month since some time before January 1, 2010, but that was not true.

7. My plan of care which was approved on August 25, 2009 contained 104 hours a month of respite services, however, DDSN reduced my respite hours to 68 hours a month on December 30, 2009 and those respite hours were not restored when I filed my administrative appeal.

8. When my respite caregiver submitted her timesheet for December 21 through 27, 2009, the Laurens County DSN Board would not pay her for all the hours she worked, because they said that I was prohibited from receiving more than 68 hours a month of respite services. Her total hours that month were less than the 104 hours which had been approved on my plan of care.

9. DDSN did not increase my respite hours until May 20, 2010, three days after Dr. Lacy signed a sworn statement saying that I was receiving 112 hours a month and that I had received this number of hours since before January 1, 2010. Her statement was not true.

1

10. When my attorney informed DDSN that my mother was in ICU and was not expected to live, they increased my respite hours by 4 hours a day for just three days. According to the authorization, this approval was only for one month and was a "one time request."

11. According to an assessment conducted by DDSN in August 2009, I was determined to need 22 hours of PCA II services a week, however, DDSN reassessed my needs the following month and determined that I required an additional 64 units (16 hours) a week. Then in October 2009, DDSN reassessed my need for PCA services and determined that I required 52 hours a week. However, on December 30, 2009, DDSN reduced the number of PCA services I received to 28 hours a week, without reassessing my need for this service.

12. I appealed this reduction and DDSN returned my PCA hours to 52 hours a week, not the 56 hours a week as Dr. Lacy stated in her affidavit. DDSN has only been paying for 52 hours a week, even though Dr. Lacy informed this Court that they were providing 56 hours a week.

13. Dr. Lacy stated in her affidavit that I was receiving 112 hours per month of respite services before and after January 1, 2010. That is not true. DDSN did not increase my respite hours to 112 hours a month until May 20, 2010

14. When my respite provider sent a timesheet into the Laurens DSN Board showing that she had worked more than 68 hours before May 20, 2010, they reduced her hours and told her that I was not allowed to receive more than 68 hours a month of respite services.

15. My plan of care and service authorizations are attached as Exhibits 1 and 2.

16. My mother was buried on June 21, 2010, but my attorney, my PCA (Amber Plaia) and ~~my~~ attorney met with the Director of the Laurens County DSN Board, Jason Tavvenor, Jean Rammage (Service Coordination Supervisor) and my service coordinator that morning to discuss my need for additional PCA hours.

17. My PCA and I told them that she arrives around 8:15 in the morning and that it takes until nearly noon for her to get me out of bed, assist me with toileting, bathe me, feed me and give me my medicine. Then she fixes my lunch and takes me to medical appointments.

18. I cannot go to the bathroom, fix anything to eat or drink or even get into or out of bed by myself, so I need someone to be with me at all times.

19. We discussed with Mr. Tavennor and his staff that I need 14.75 hours a day (104 hours a week) of PCA services and additional hours during the months when I work as a coach for the Clinton High School football team, but he said that DDSN will only provide 56 hours of PCA services a week.

20. At that meeting, I asked for DDSN to provide 240 hours a month of respite services until the Court rules on my request for PCA services.

21. My attorney asked for a copy of the assessment they had used to determine that I only need 112 hours of respite services, but they could not provide an assessment and they could not explain why I do not qualify to receive the maximum number of hours of respite services.

22. We asked Mr. Tavvenor and his staff about the other alternatives that Kathi Lacy had said in her affidavit that I could receive instead of PCA services, but the only service they offered was a day program "community" program where I would be required to go into the community with a group of other people who have disabilities.

23. Mr. Tavennor said that there are no beds available in Laurens County, so that residential habilitation is not an option for me. He did not discuss the option of ICF/MR respite services or Adult Companion Services.

24. I asked for an assessment to evaluate my assistive communications device to determine whether there are assistive devices that would improve my ability to communicate and they agreed to schedule an assessment.

25. Mr. Tavennor and his staff were unable to tell us about any other services that would decrease my need for PCA services.

26. Because of the low rate of pay for respite, it is difficult to find respite caregivers because the DSN Board requires the respite workers to pay fica tax, with the pay after fica taxes are deducted being below minimum wage.

27. No one at the meeting told us that they pay an additional $2.00 an hour for "difficulty of care." Mr. Tavvenor said that I am the employer of record for respite services and that I would be responsible for paying Workman's Comp and liability coverage in case a respite caregiver were hurt on the job, but I do not have money to pay those costs.

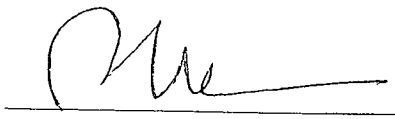
28. I have recently learned that the DSN Board does not pay workman's comp or unemployment taxes on respite workers.

29. I do not want to ~~attend a congregate~~ program or live in a congregate setting where I would be ~~required to~~ spend my time segregated from non-disabled persons.

I have reviewed this affidavit and swear that its contents are true, to the best of my knowledge. Executed on the 22 day of June, 2010.

Jimmy "Chip" Eubanks, Jr.

SWORN TO BEFORE ME THIS
22 day of June, 2010.



STATE OF SOUTH CAROLINA)
) AFFIDAVIT
COUNTY OF LAURENS)

1. I have been the treating physician of Jimmy "Chip" Eubanks, Jr. for 9 years.

2. Chip has profound cerebral palsy and is unable to use his arms or his legs.

3. Chip is able to drive his wheelchair using a special device attached to the chair.

4. Chip requires assistance with all activities of daily living.

5. Chip is unable to toilet, bathe, feed or transfer himself from his wheelchair or his bed.

6. Chip requires assistance with feeding/eating, toileting, bathing, shaving, dressing and grooming, cooking and doing laundry and taking his medications.

7. Chip's mental and physical condition would deteriorate if he were required to move into a congregate living facility.

8. It would be inappropriate for Chip to be forced to attend a day program with other disabled persons, where he would be segregated from non-disabled persons.

9. To maintain his safety, Chip requires a personal care attendant from the time he wakes up until he goes to bed and he needs someone in the house with him to assure his safety during the night.

10. Chip requires someone to assist him with ambulation and positioning and he is at risk of getting decubitus ulcers if he does not have a personal care attendant during all waking hours.

11. Chip needs someone to assist him with activities like laundry and cleaning and transporting him to medical appointments.

I have read this affidavit and swear that it is true, to the best of my information and knowledge.

Edgar B. Barnard MD

6/23/10

SWORN TO BEFORE ME
this 23 day of June, 2010

Clinton Family Practice
864 833-2120

STATE OF SOUTH CAROLINA)
) AFFIDAVIT OF AMBER PLAIA
COUNTY OF LAURENS)

1. I have provided PCA II (personal care attendant) services for Chip Eubanks ~~since~~ (through 05/2010).

2. I have also provided respite services for Chip.

3. Until May 20, 2010, I was told that Chip was only approved to receive 68 hours a month of respite services.

4. When I provided more than 68 hours in one month of respite and recorded those hours on my timesheet, Chip's DDSN service coordinator called to tell me that he was not authorized to receive more than 68 hours a month of respite and she reduced the number of hours on my timesheet, so that I was only paid for 68 hours, even though I had worked more hours.

5. The Laurens County DSN Board pays me $8.30 an hour for respite services, but I am required to pay fica taxes out of that amount, so that the net is less than minimum wage.

6. The DSN Board informed me that I am not an employee of the Laurens DSN Board when I provide respite services, but they require me to receive training from them and to comply with all of their rules.

7. The Laurens DSN Board does not provide Workman's Comp or unemployment benefits for respite caregivers, so that if I was hurt on the job while providing respite services, DSN would likely deny liability for workman's comp. (Affiant does not acknowledge that the DSN Board is not liable as an employer.)

8. Respite caregivers have to take training from the Laurens DSN Board and meet all the requirements set by the DSN Board.

9. I would not be able to continue to serve Chip if his PCA hours were reduced to 4 hours a day because I cannot afford to live on the rate paid to respite workers.

10. Chip can drive his wheelchair with his mouth once someone gets him out of bed and into the wheelchair and he can use his computer once I put a device on his head, but he cannot do anything else for himself that requires physical movement.

11. At the meeting on June 21, 2010, Chip's attorney asked the director of the Laurens DSN Board and his two employees what alternative services are available to Chip, but the only service they could offer was a service which would require Chip to spend his days going into the community with a group of persons who have disabilities.

12. They could not explain why Chip was determined to require less than the maximum number of hours of respite or how the need for respite is determined.

13. Chip wants to spend his days with people who are not disabled.

14. The director told Chip that there are no beds in Laurens County and said that he was not aware of any open beds located in other parts of the state.

15. Chip's mental condition would deteriorate if he were required to live or spend his days in a congregate setting.

16. Chip's biggest fear is having to move to an institution.

17. Since his mother died, Chip does not have a family member who is available to provide care for him on a daily basis.

18. I arrive around 8:15 in the morning and it takes until nearly noon getting Chip ready (toileted, bathed, dressed, groomed and fed). He requires someone to feed him all of his meals, to take him to the bathroom and to put him into and out of the bed.

I have read this affidavit and swear that the contents are true, to the best of my knowledge and understanding.

Amber D. Plaia
Amber Plaia

SWORN TO BEFORE ME THIS
22 day of June, 2010

At the meeting on June 21, 2010, Chips attorney repeatedly asked what Chip's options were and what alternatives were available. She told the director of the DSN board that the rate for respite is less than minium wage, once Fica taxes are deducted. He never told us that there is a "difficulty of care rate" for respite which pays $2.00 an hour more. Amp

Chip weights 185 pounds. If he could stretch all the way out, he would be 6 foot 2 inches tall. Chip is totally unable to assist with transfers because of spacicity. He requires assistance with every activity because he has no control of his arms or legs. Amp

STATE OF SOUTH CAROLINA)
)
COUNTY OF LAURENS)
)

AFFIDAVIT OF JIMMY W. "CHIP" EUBANKS

Now comes Jimmy W. "Chip" Eubanks who swears and affirms that:

1. I am36 years old and I have severe cerebral palsy. I do not have mental Retardation. My mind works Fine.
2. I am unable to get out of the bed without assistance and I require help with all activities of daily living, including bathing, dressing and preparing my meals.
3. I live in the home of my parents, but they are not able to take care of me anymore.
4. My mother has brittle diabetes, a fractured hip and she has had an aneurism. She had open heart surgery.uses a wheelchair because she cannot walk anymore. All she can do is shuttle because of the diabetes.
5. My father works when he can, but he has a fractured disc and some days he is not able to get out of bed to go to work as a logger.
6. For many years I have helped to coach the Clinton High School football team, a volunteer job. If my services are cut, I will not be able to continue to coach.
7. I was getting 8 hours a day of PCA (Personal Care Attendant) II services, but on January 1, 2010, DDSN cut my PCA services to 4 hours a day.
8. It takes a long time every day to get me out of my bed, showered and dressed and into my power wheelchair. I am able to drive my wheelchair with a ~~sip-and-puff~~ device, which allows me to control it with my mouth.
9. At first I was afraid to appeal the reduction in my services because my service coordinator scared me into believing that my income would be taken by Medicaid if I lost my appeal.
10. ~~When I appealed the reduction in my services, DDSN sent a letter informing me that limits on my PCA services cannot be exceeded (28 hours a week).~~ .
11. In the letter from Dr. Buscemi, DDSN said that I have been found to be severely disabled, but they did not tell me how many respite hours I would receive.
12. My biggest fear is having to go to an institution, but I will be forced to move to an institution if DDSN reduces my PCA services and the statement contained in Exhibit 1 was prepared by me and is true.

This affidavit is correct to the best of my knowledge. Executed this 18 day of January, 2010.

Jimmy W. "Chip" Eubanks

Sworn to me this 18th day of January, 2010.

Notary Public for South Carolina Expires 8-14-2017

This affidavit was read to Jimmy W. "Chip" Eubanks and he requested the changes and made his mark beside the changes.

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POLITICS | MAY 20, 2010

Disabled Face Hard Choices as States Slash Medicaid

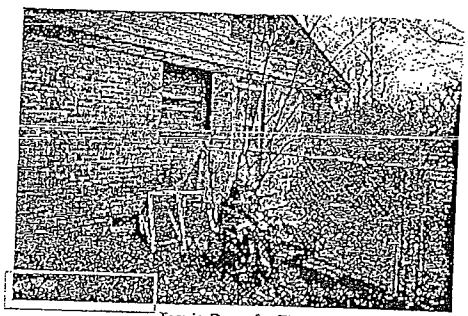
By CLARE ANSBERRY

FLORENCE, S.C—Tandem forces of shrinking state budgets and rising health-care costs have collided and struck a small brick ranch house in this rural town, home to Barbara Hickey.

Born with cerebral palsy, Ms. Hickey, now 67 years old, is confined to a motorized wheelchair. She lives alone and relies on-certified nurse's assistants to get her in and out of bed, bathed, clothed and fed.

In December, she received a letter from the South Carolina Department of Special Needs and Disabilities, saying her weekly 50 hours of personal-care help was being cut to 28 hours. That meant Ms. Hickey would get help for two hours in the morning and two hours at night. If she needed to use the bathroom in between, she would sit in a soiled diaper.

Struggling to Stay Home

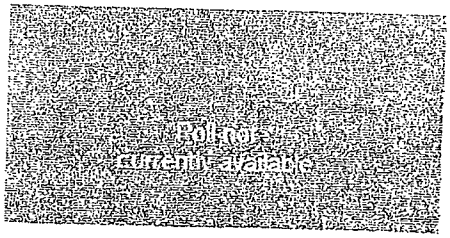


Travis Dove for The Wall Street Journal

Outside of his home, Chip Eubanks gave water to his dogs using a homemade mount that attaches a hose to his wheelchair. Taking care of his dogs is one of his favorite activities.

More photos and interactive graphics

Journal Community



After several days of reduced care, the local office of the South Carolina Legal Services appealed the cuts on behalf of Ms. Hickey. Her hours have been restored pending the appeal.

Home health care—funded largely by Medicaid—generally costs less money than institutionalizing developmentally disabled people like Ms. Hickey. But the political reality is that it's easier to cut back home services than to close a 24-hour facility, which can leave people with nowhere to go. Thus, some of the biggest cuts around the country are happening in the basic services that help the disabled cope at home.

South Carolina says it has little choice but to cut funding for Medicaid. It faced a $563 million deficit for the current fiscal year, and like other states must have a balanced budget. Medicaid, the joint federal-state health-insurance program for the poor and disabled, already consumes about 20% of its $5 billion budget and is one of its fastest growing costs.

The health-care program is on course to consume 40% of the budget of South Carolina in five years, and leaves little for anything else, says Gov. Mark Sanford. "It could force legislators to either cut further into bone in the areas of education, law enforcement and economic development, or raise taxes. Neither option is palatable."

The state already is making painful cuts elsewhere. The state's Department of Juvenile Justice has closed five group homes and cut 25 after-school programs. There are 1,000 fewer public-education teachers this school year than last.

Across the country, budget-strapped states are focusing on Medicaid. Created in 1965, it is now a $379 billion program, including state and federal funds. State spending grew an average 7.9% in fiscal 2009 as the economic crisis hit and more people signed up for Medicaid.

It was the highest growth rate since the last downturn six years ago. Spending is expected to keep growing at that pace for the next decade because of rising costs and growing enrollment.

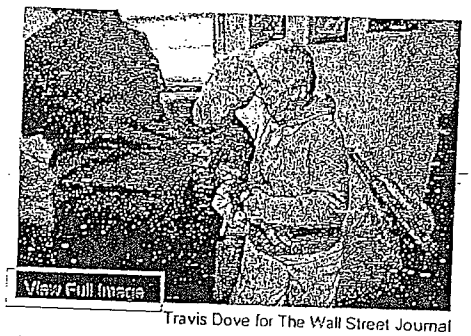
But states don't have much flexibility when it comes to what they can and can't cut inside Medicaid. Although it is a state-managed system, the federal government pays a percentage of each state's total costs and makes many of the Medicaid rules. Under federal Medicaid law, states must offer inpatient and outpatient hospital care, X-rays and lab services. They also have to cover nursing-home services and meet certain standards, such as staffing ratios.

There are further constraints this year. States can't reduce Medicaid eligibility this year because of a condition attached to federal stimulus money, and under health-care reform, they can't eliminate existing programs.

States also run up against other laws when they make deep cuts. Lawsuits have been filed in South Carolina, Florida, Connecticut, Virginia, Mississippi and New York, claiming Medicaid cuts make it impossible for those with disabilities to live at home and that it violates the Americans with Disabilities Act.

Logically, states would cut the most expensive, least efficient services and keep the most cost-effective. But because of mandates and the need to save money quickly, that isn't as easy as it sounds.

For example, home care—because relatives often provide some of the care—is generally cheaper than housing people with developmental disabilities in institutional facilities. In 1993, the average Medicaid cost for each person with disabilities was $48,500. At the end of 2008, the latest figures available, it cost an average $55,000. Adjusted for inflation, that actually represents a 23% decrease, largely as a result of more services being shifted away from costly institutions to the home, says Charlie Lakin, director of a University of Minnesota program that tracks services for the developmentally disabled.



Travis Dove for The Wall Street Journal

Chip Eubanks and his mother Linda.

But many in-home services, though critical to those receiving them, are optional. Furthermore, there aren't many minimum standards set for in-home services, so it's easier to cut them without violating funding requirements. There are fewer immediate consequences for the state when it cuts those services because families won't generally abandoned disabled relatives and leave states on the hook for housing.

Cutting home care could ultimately prove penny-wise and pound-foolish, however. It could push more people into institutions or large group homes because that is where services are guaranteed, even though institutional care is more expensive.

Although only about 10% of the Medicaid budget goes to treat the 618,000 developmentally disabled Americans—the same percentage as a decade ago—average spending for each person is more than 10 times higher than for all Medicaid recipients. "Since their services cost the most per person they draw attention," says Mr. Lakin.

New Mexico has cut cash assistance payments for low-income disabled residents by one-third. Vermont and California have made cuts to home-based programs for the disabled.

Some of the biggest cuts are coming in South Carolina. Tax increases are particularly hard to pass here, so lawmakers rely largely on spending cuts to balance the budget.

Since 2008, the Department of Disabilities and Special Needs has lost 28% of its base funding, eliminated physical, speech and occupational therapies and capped the amount of diapers and nutritional supplements provided to people living at home. Seven group homes were closed.

The department's fiscal problems have been exacerbated by past spending decisions. A special state audit released in December 2008 showed that the department hadn't provided many new services for which it had received funding and, as a result, it couldn't recoup millions in federal matching Medicaid dollars. For example, the state spent less than $700,000 of $10 million allocated to serve autistic children, which resulted in the loss of $13.6 million in federal matching money. The state said it couldn't ramp up the program fast enough because it couldn't find qualified service providers. After the audit, the executive director of the department and four of the department's seven commissioners resigned. The department has since implemented most of the recommendations made by the Legislative Audit Council.

Recent state cuts have targeted developmentally disabled people living at home. In December, families were told that some of their in-home support was being cut by as much as half.

Brian Phillips, a 37-year-old with cerebral palsy, was told that he was losing half of his personal-care hours. He can work a TV with a remote control but can't dress or feed himself, or get in and out of his bed or wheelchair.

He lives alone with his father, James, 70. The elder Mr. Phillips, who has had open heart surgery and whose heart functions at only 26% of its capacity, cannot lift Brian on his own. He appealed the cuts and the hours were restored pending his appeal.

"These are cuts no one wants to make. They are very difficult for agencies to implement and they are very upsetting and very, very difficult for our families," says Lois Park Mole, spokesperson for the state Department of Disabilities and Special Needs.

People will generally do what they must to keep their disabled family member at home regardless of the cuts. At some point, however, even the most dedicated may not be able to continue, especially as their own health deteriorates.

Jimmy "Chip" Eubanks of Clinton, S.C., has severe cerebral palsy, but doesn't have mental retardation. "My mind works fine," he says. The 37-year-old has a full life at home. He can drive his motorized wheelchair with his mouth and use a computer with a stick-like device attached to his head. During the football season, he writes notes to the Clinton High Red Devils team and prepares plays for them. He hasn't missed a game in 18 years.

"My biggest fear is having to go to an institution," he says.

His parents were able to take care of Chip on their own until about three years ago when Linda Eubanks, now 68, had a brain aneurism. Already diabetic, the aneurism further compromised her health. She is nearly blind and in a wheelchair.

She can't see well enough to drive, use the stove or feed her son. Her husband has a bad back and can't lift Chip, who is 6 feet tall and weighs 185 pounds.

The couple relies on Amber Plaia, a certified nursing assistant. Ms. Plaia gets Chip out of bed, bathes, dresses and feeds him. She takes him to doctors' appointments.

In the evening, Chip's uncle, who lives nearby, can put him into bed most nights. Otherwise, Chip sleeps in his wheelchair.

Chip's personal-care help—essentially Ms. Plaia—has been cut in half to four hours a day. He appealed and his hours were restored pending the appeal. He, and three others, have filed suit against the state, saying the cut violates the Americans with Disabilities Act.

Journal Community DISCUSS

I understand the need for fiscal responsibility, but I hope states can continue to help those with disabilities to not only live in a dignified manner, but to continually improve it as well.

—Jim Campbell

Ms. Park Mole said people like Chip could get "respite care" to help make up for the loss of personal-care help. Medicaid also helps pay for respite care, which costs less because the workers provide a lower level of care.

In some parts of the state, personal-care workers are paid $12 an hour and respite-care workers about $8 an hour.

Families said that isn't always a feasible option. Respite-care workers aren't expected to bathe people or clean breathing tubes, and families say it can be hard to find qualified ones.

In Aiken County, Board of Disabilities Executive Director Ralph Courtney says waiting lists for services are growing. There are more than 5,000 on waiting lists for various services, from residential programs to in-home programs.

"We want to give families hope to keep their family unit together, but in reality there is very little we can put in place to assist them," says Mr. Courtney.

In-home support is cheaper, he says, than the alternative: group homes and larger residential programs that need to be maintained and staffed 24 hours a day. "But you can't put people out on the street," he says. "You can cut in-home support."

Even though Ms. Hickey lives alone and needs help with nearly every aspect of daily living, it cost less to have her live in a house with 50 hours of personal care help than in a nursing home. Institutional care in South Carolina costs about $100,000 per person a year, compared to $39,000 for home and community services, according to the University of Minnesota research.

There are other considerations. Though disabled since birth, and barely able to read or write, Ms. Hickey is aware of her surroundings and her situation.

She enjoys being able to go outside the back door, which is equipped with an automatic opener, onto a porch. She can ride her motorized wheelchair down the street to Burger King. She doesn't want to live in a nursing home, institution or group home. "I'm not losing my mind. I just don't have a body to do things other people can," she says.

The cuts for the developmentally disabled are almost certain to bite deeper in the future. Part of the federal stimulus money this year was designed to prop up Medicaid. The federal infusion disappears for the fiscal year starting in July 2011.

South Carolina faces an even bigger budget deficit of $1.1 billion when the one-time money runs out.

Write to Clare Ansberry at clare.ansberry@wsj.com

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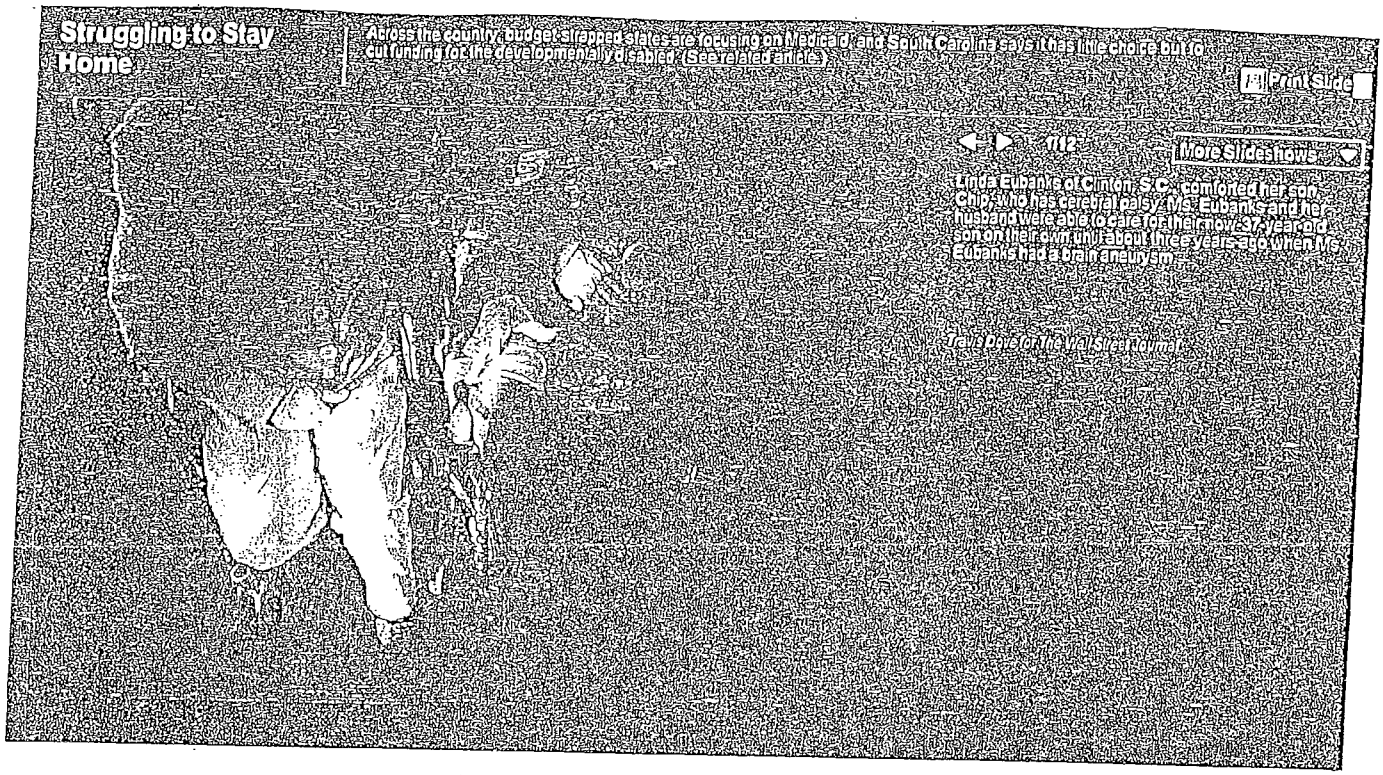
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Across the country, budget-strapped states are focusing on Medicaid, and South Carolina says it has little choice but to cut funding for the developmentally disabled. (See related articles.)
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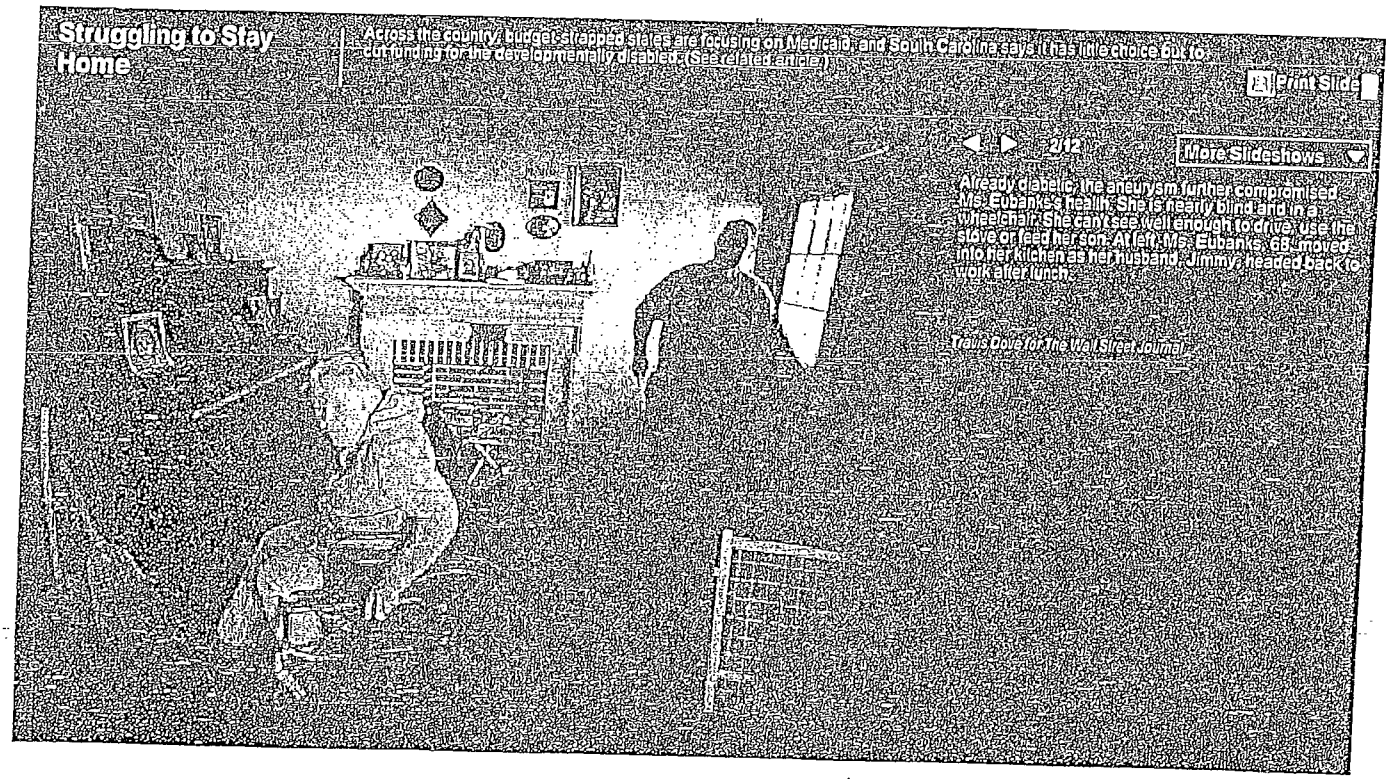
Linda Eubanks of Clinton, S.C., comforted her son Chip, who has cerebral palsy. Mrs. Eubanks and her husband were able to care for their now 37-year-old son at her own until about three years ago, when Mrs. Eubanks had a brain aneurysm.
Travis Dove for The Wall Street Journal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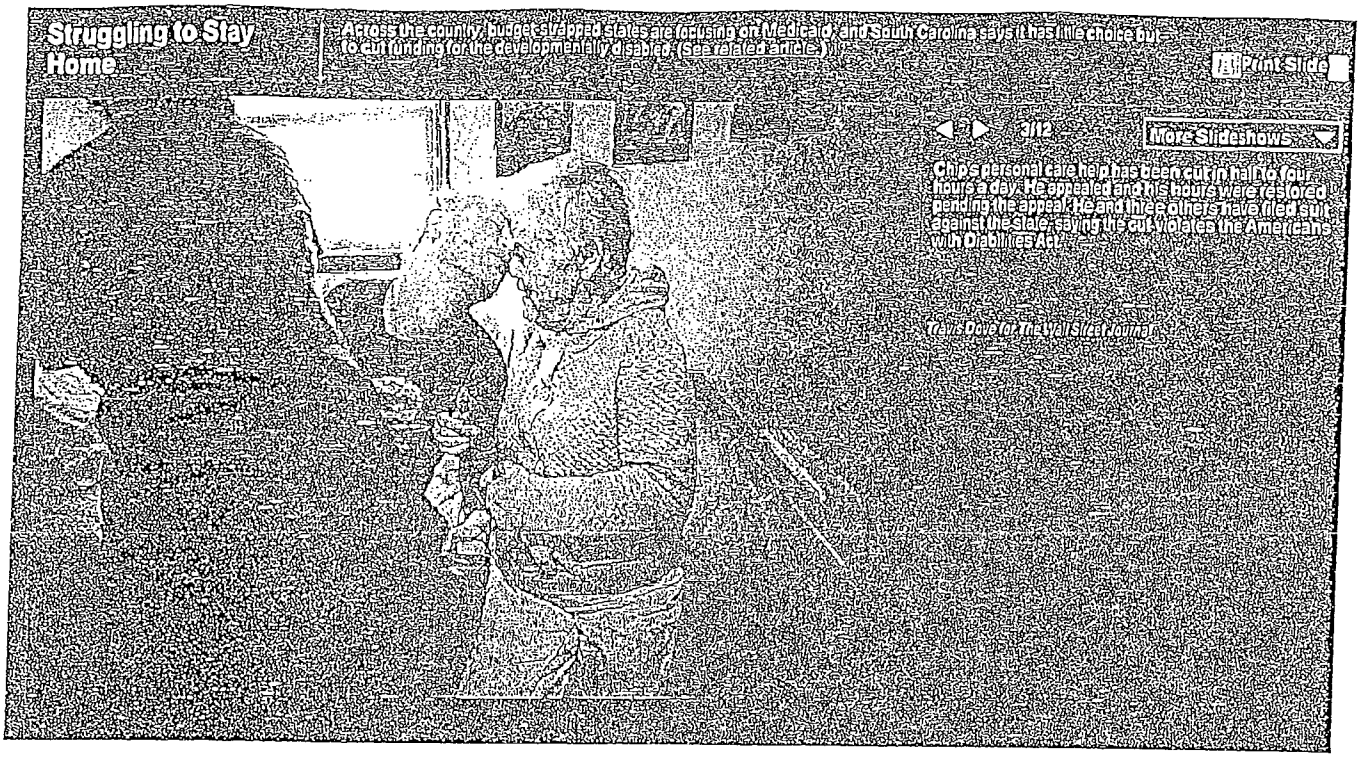
Already diabetic, the aneurysm further compromised Mrs. Eubanks's health. She is nearly blind and in a wheelchair. She can't see well enough to drive, use the stove or feed her son. After Mrs. Eubanks's GB moved into her kitchen as her husband, Jimmy, returned to work after lunch.
Travis Dove for The Wall Street Journal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Chris's personal care help has been cut in half to four hours a day. He appealed and his hours were restored pending the appeal. He and three others have filed suit against the state, saying the cut violates the Americans with Disabilities Act.
(View Door for The Wall Street Journal)

Struggling to Stay Home
Across the country, budget-strapped states are focusing on Medicaid and South Carolina says it has little choice but to cut funding for the developmentally disabled. (See related article.)
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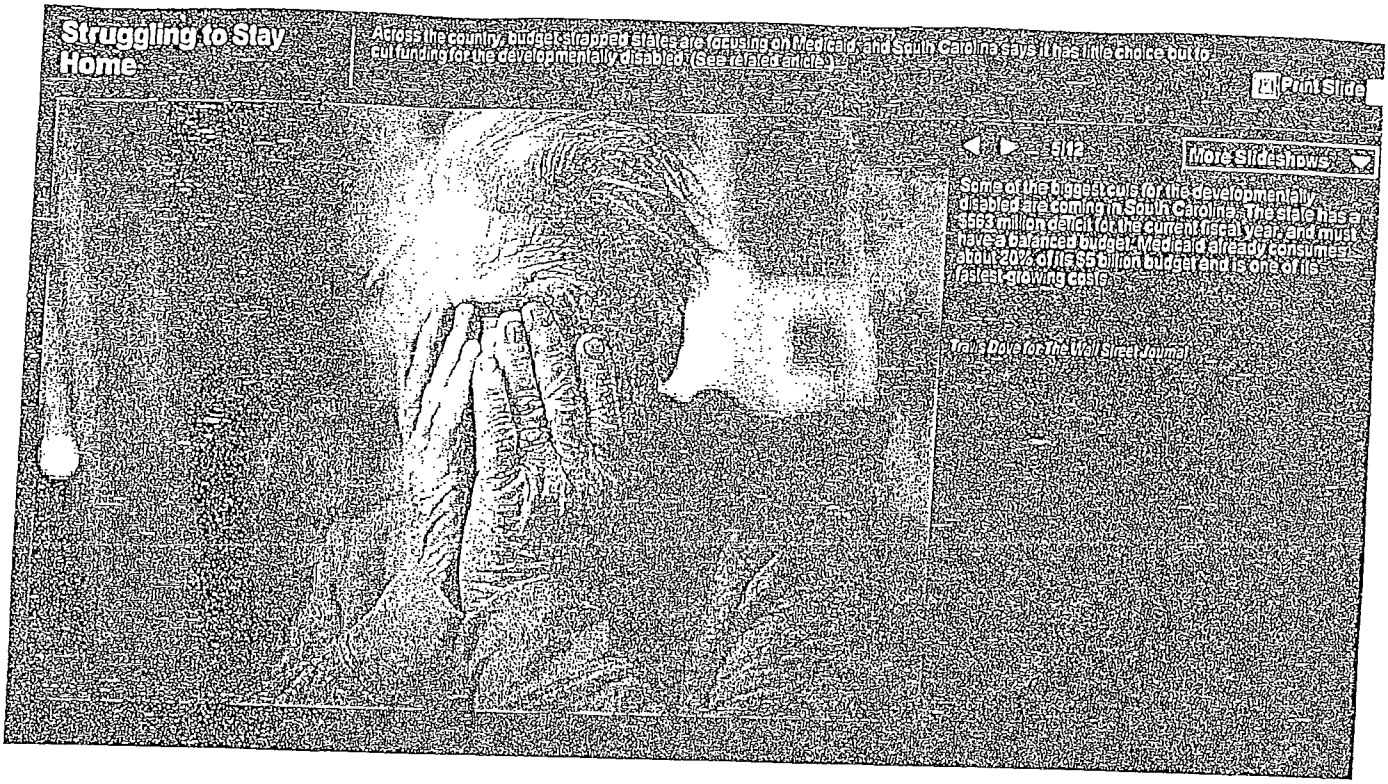
An old portrait of the Eubanks family shows Linda Eubanks, second from left, before illness forced her into a wheelchair.
(View Door for The Wall Street Journal)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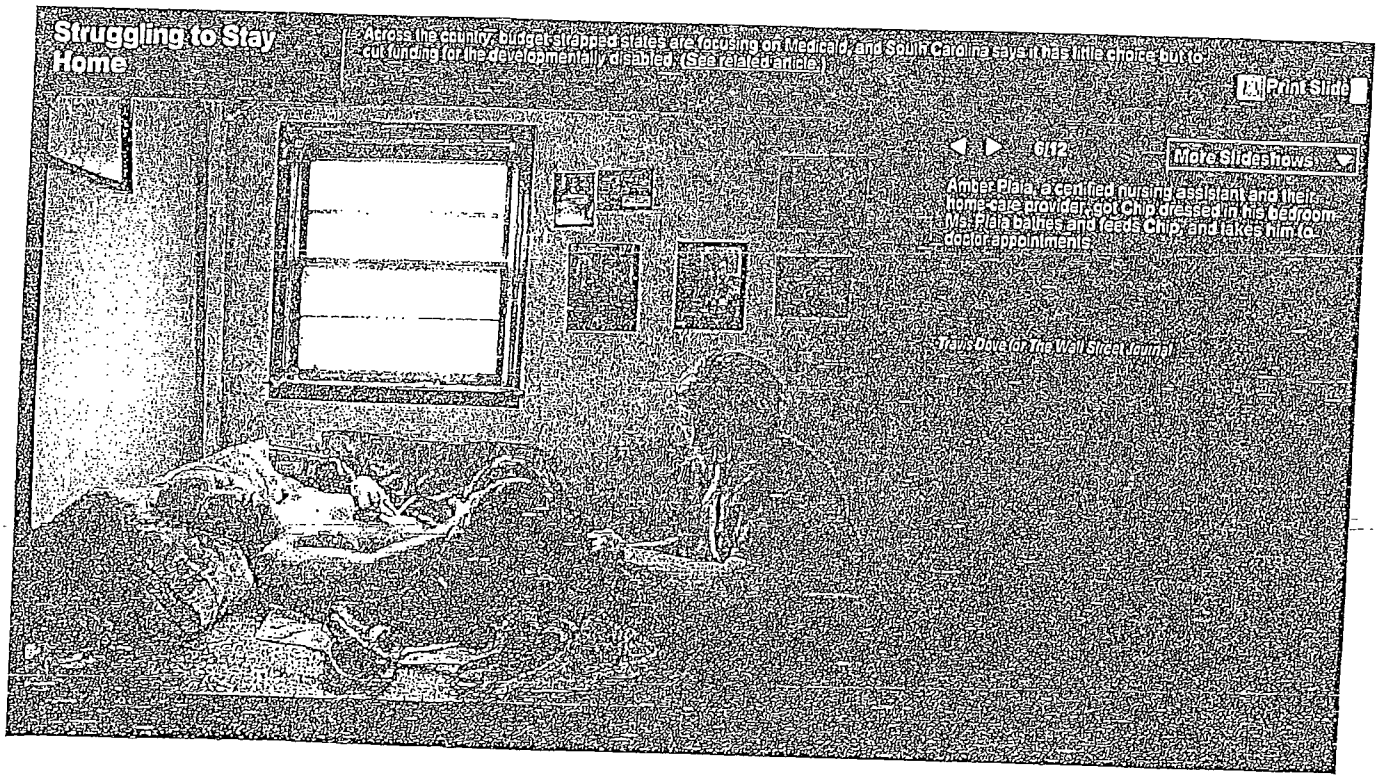
Some of the biggest cuts for the developmentally disabled are coming in South Carolina. The state has a $493 million deficit for the current fiscal year and must have a balanced budget. Medicaid already consumes about 20% of the $5 billion budget and is one of the state's fastest-growing costs.
Photo: Dale Atkins for The Wall Street Journal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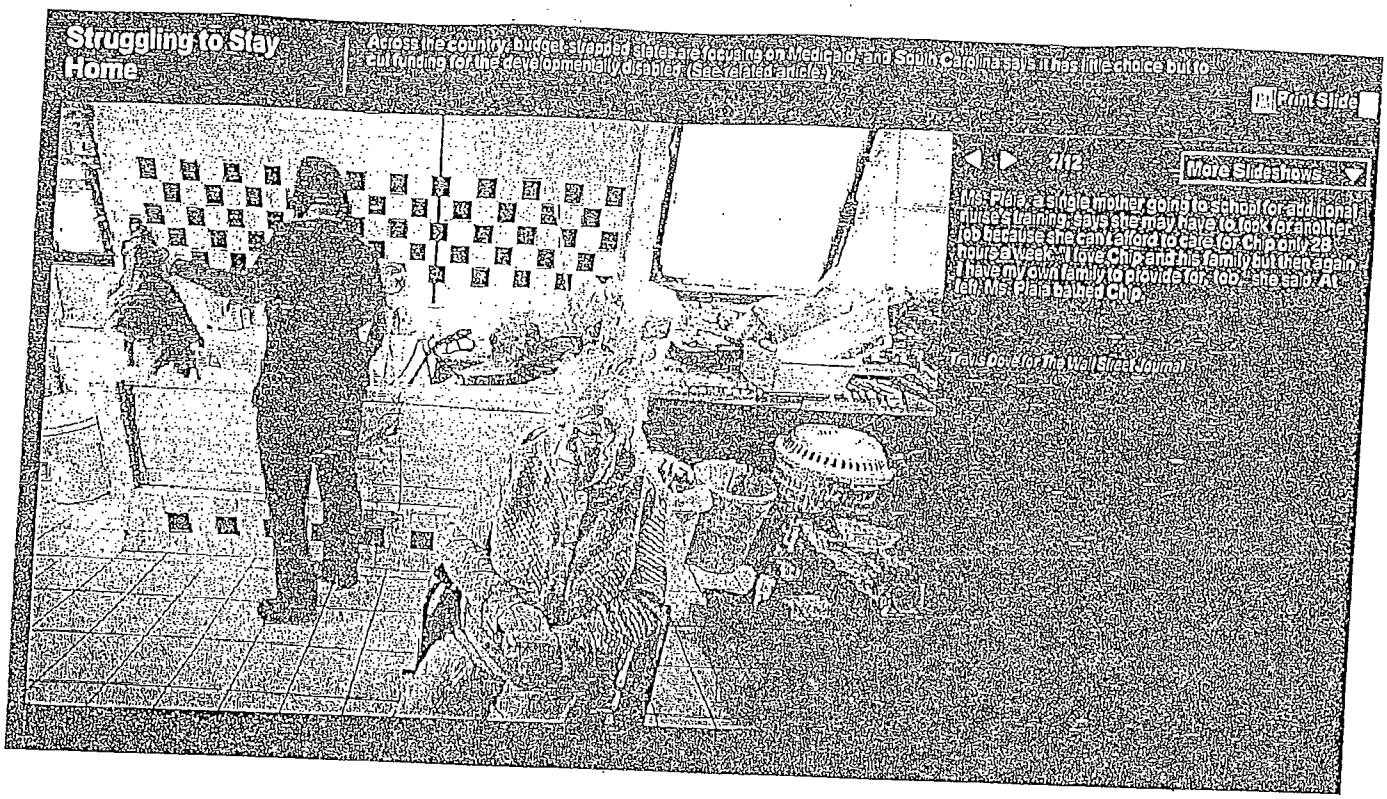
Amber Plaia, a certified nursing assistant and their home-care provider, got Chip dressed in his bedroom. Ms. Plaia bathes and feeds Chip, and takes him to doctor appointments.
Photo: Dale Atkins for The Wall Street Journal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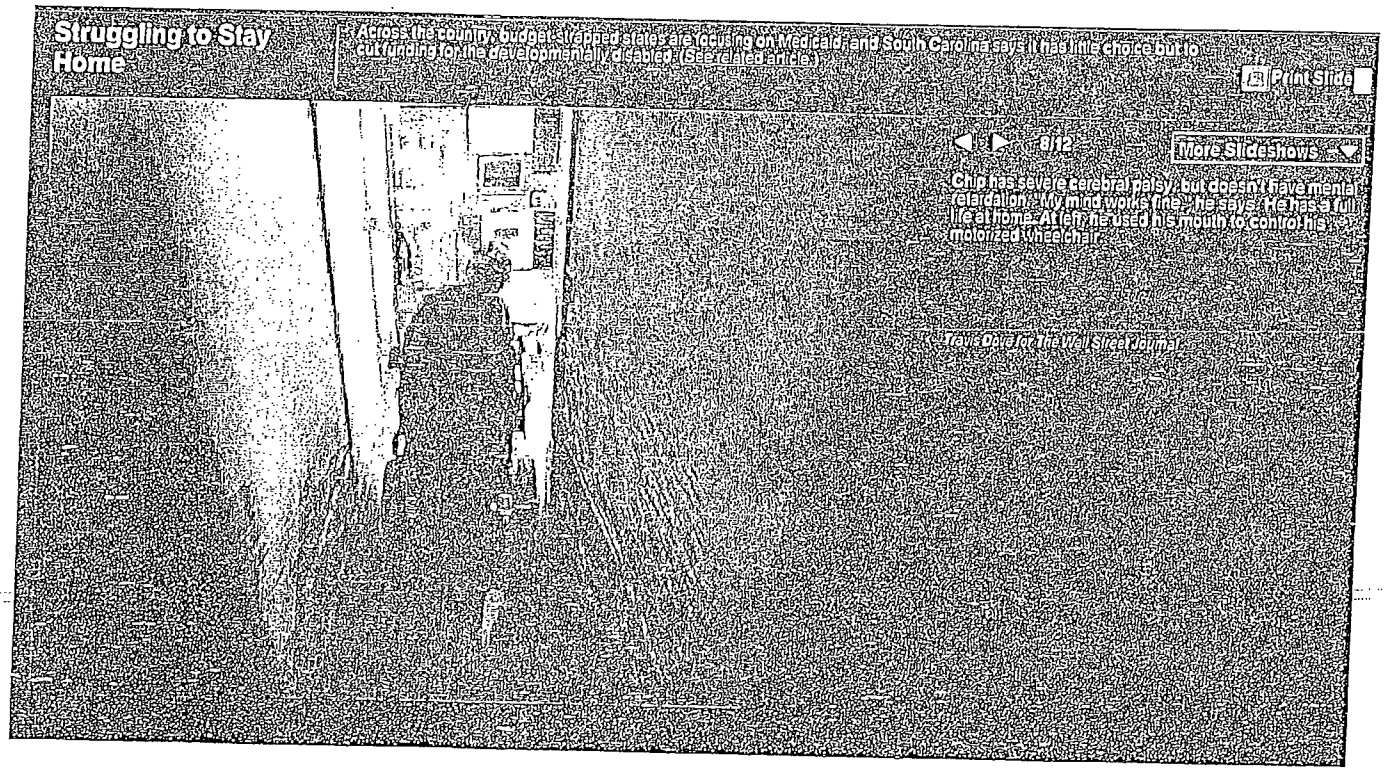
Ms. Plaxco, a single mother going to school for additional nursing training, says she may have to look for another job because she can't afford to care for Chip on a 28-hour-a-week job. "I love Chip and his family, but then again I have my own family to provide for, too," she said. At left, Ms. Plaxco bathed Chip.
Tara Dowdell for The Wall Street Journal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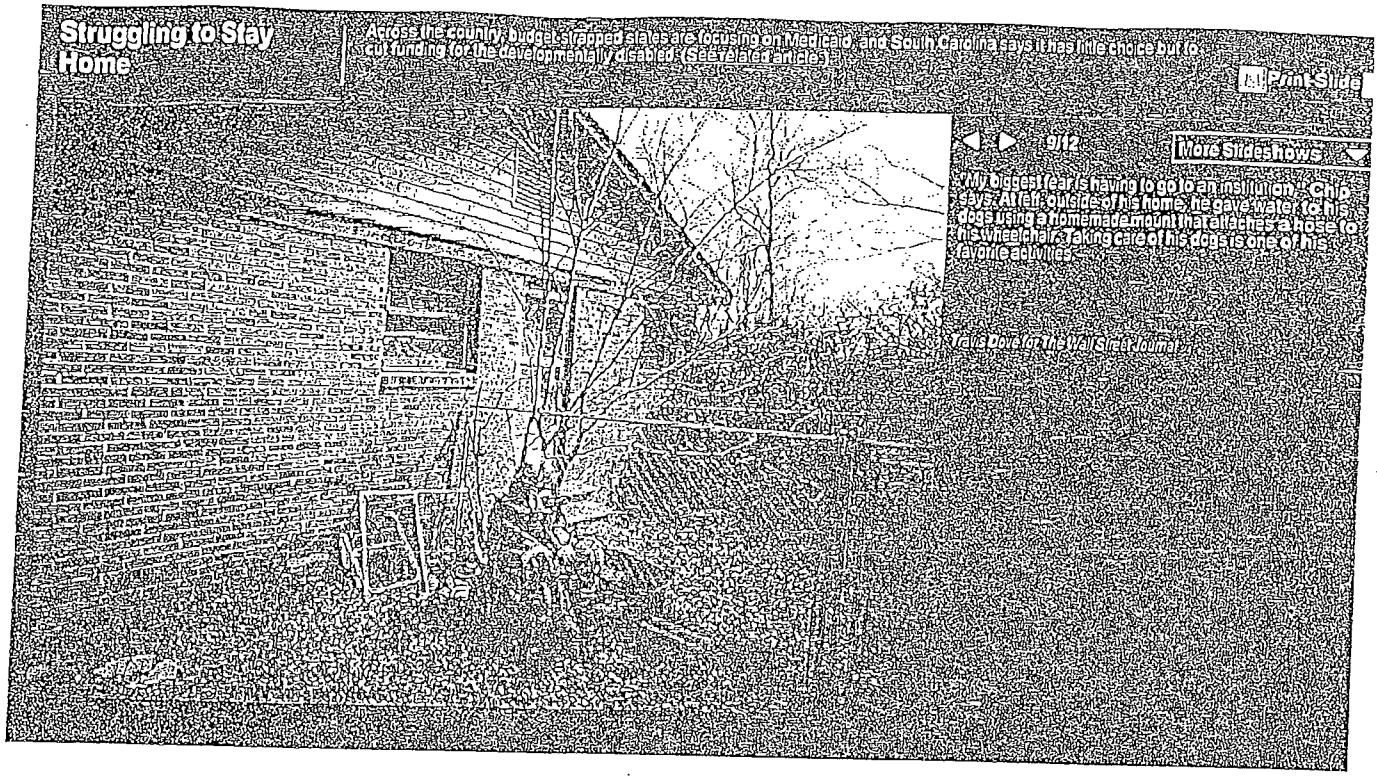
Chip has severe cerebral palsy, but despite his impairments, relatives say, his mind works fine. He says he still likes to live at home. At left, he used his mouth to control his motorized wheelchair.
Tara Dowdell for The Wall Street Journal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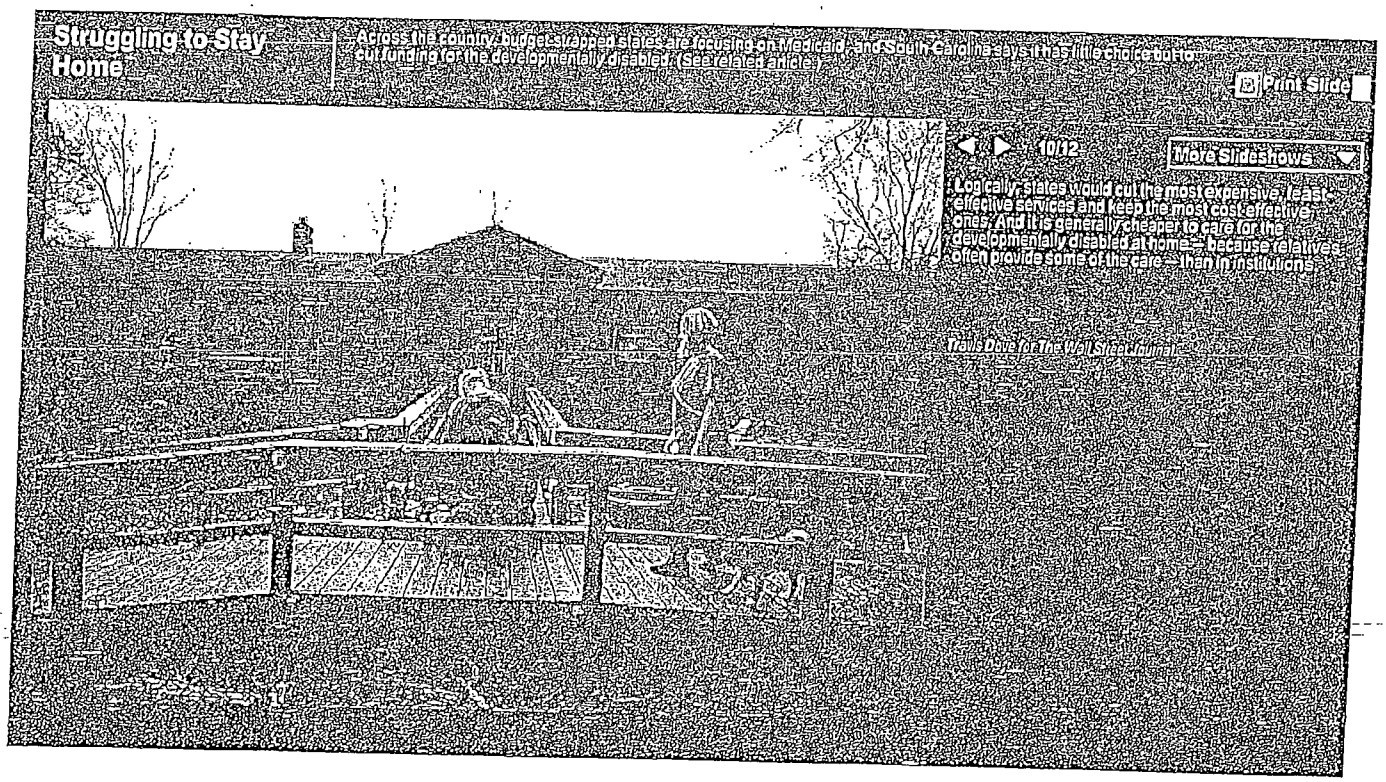
My biggest fear is having to get [an institution's] help," Chip says. After a decade of his home, he gave water to his dogs using a homemade mount that allowed him to his wheelchair. Taking care of his dogs is one of his favorite activities.
Kalia Doner for The Wall Street Journal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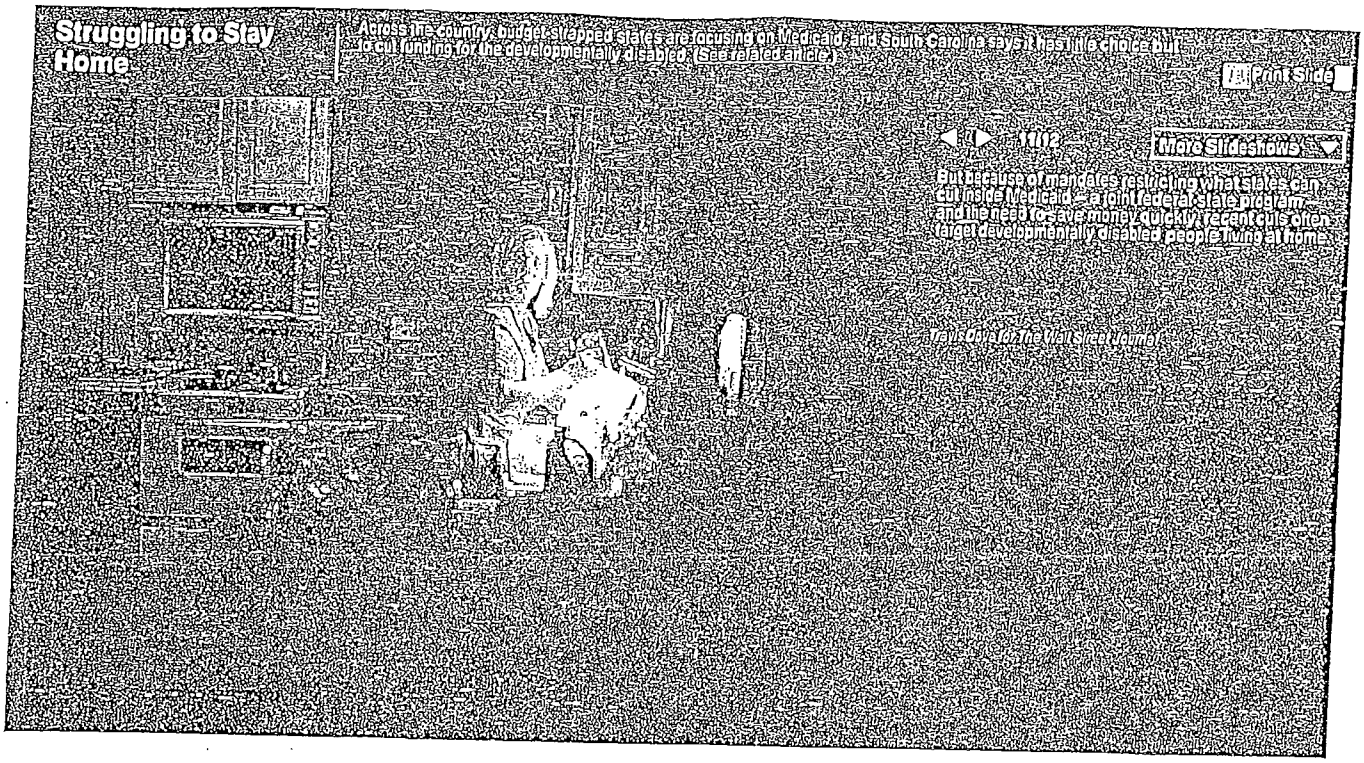
Logically, states would cut the most expensive, least effective services and keep the most cost-effective ones. And it is generally cheaper to care for the developmentally disabled at home—because relatives often provide some of the care—than in institutions.
Kalia Doner for The Wall Street Journal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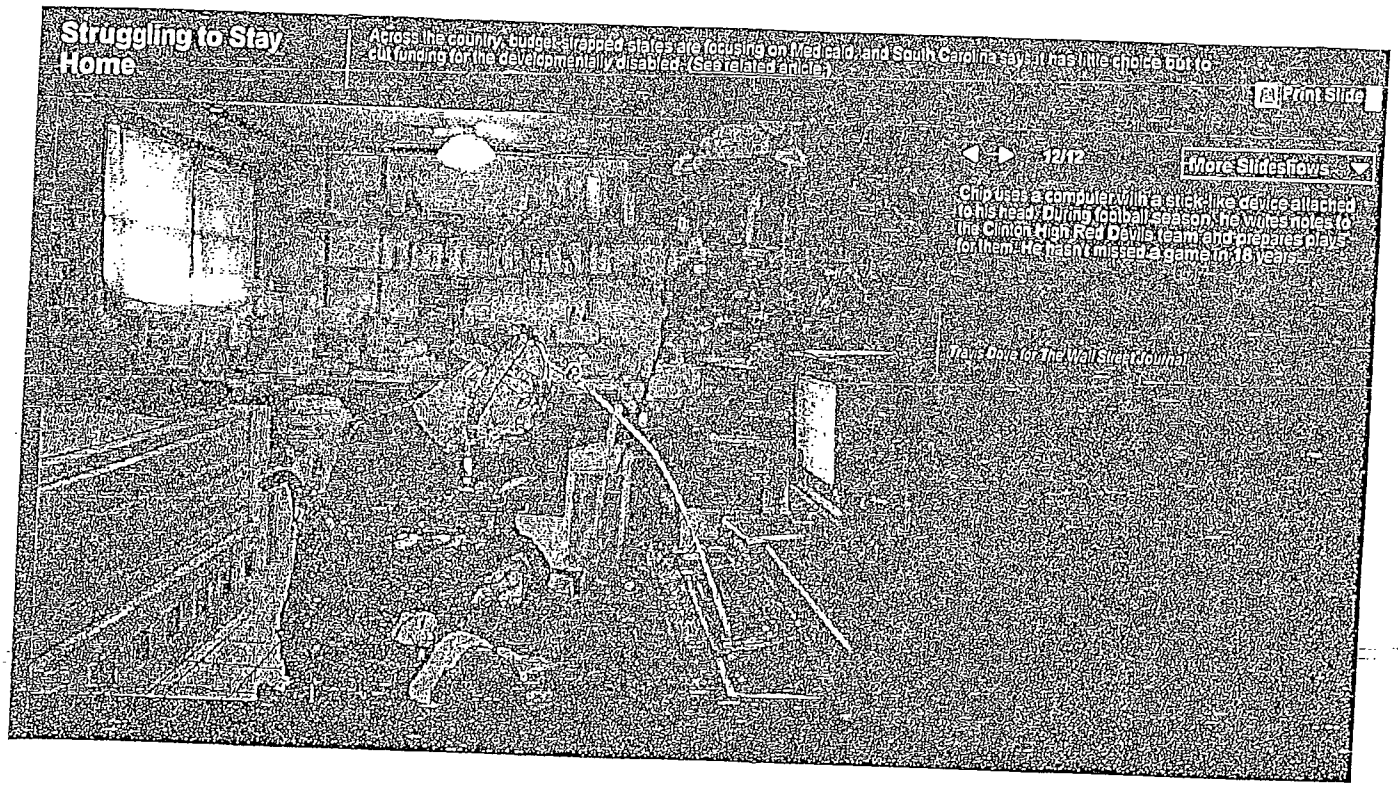
But because of mandates restricting what states can cut inside Medicaid — a joint federal-state program — and the need to save money quickly, recent cuts often target developmentally disabled people living at home.
Travis Dove for The Wall Street Journal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Chip uses a computer with a stick-like device affixed to his head during football season. He writes notes to the Clinton High Red Devils team and prepares plays for them. He hasn't missed a game in 18 years.
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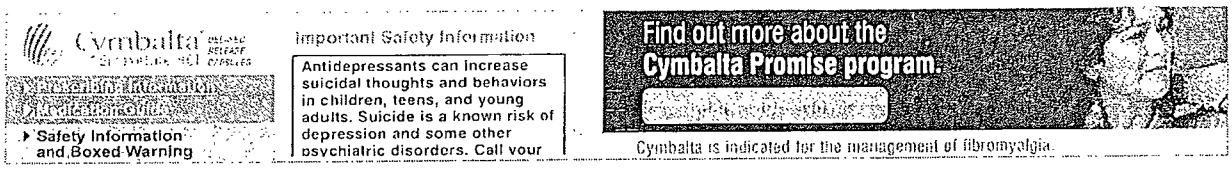

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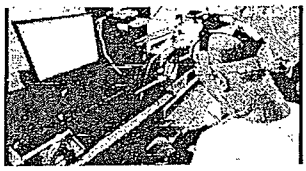

State and federal budget cuts are taking their toll on everyone. But two groups – the disabled and elderly – are especially scared that Medicaid cuts will force them from their homes.

Inside E Street features the story of Chip and Linda Eubanks, a mother and a son who are physically disabled and directly affected by the state budget cuts on home care services.

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Exhibit2

Documents Related to Michelle Morgan

STATE OF SOUTH CAROLINA)
) AFFIDAVIT OF BARBARA MORGAN
COUNTY OF LAURENS)

1. I am the mother of Michelle Morgan, who is a severely disabled adult. My affidavit more fully describing my daughter's condition is attached. Exhibit 1.

2. The statements made by Kathi Lacy saying that Michelle has been receiving 2 weeks a year of institutional respite and 56 hours a week of respite services are not true. We have repeatedly requested those services, but they have not been provided.

3. For years, DDSN has repeatedly informed us that they are unable to provide institutional respite services to Michelle because of budget reductions.

4. Soon after I filed an appeal of the reduction in Michelle's services, DDSN first told me that Michelle would receive the maximum number of in-home respite hours, which was 240 hours a month.

5. However, DDSN never provided that many hours and soon after telling us that, DDSN informed me that Michelle would only receive 30 hours a week of respite services, which is the amount she has been receiving since we filed the appeal of the reduction of her services. The statement of Kathi Lacy in her original affidavit and her amended affidavit saying that Michelle has received 56 hours a week of respite services is false.

6. A letter dated May 26, 2010 from the Laurens DSN Board confirming that Michelle receives 30 hours a week of respite is attached as Exhibit 2.

7. Michelle's plan of care entry dated January 1, 2010 states that "Only two additional hours were approved." (Referring to respite hours.) Exhibit 3.

8. Kathi Lacy says in her affidavit that Michelle's needs for services could be met by residential habilitation services, but DDSN has informed us that Michelle's needs could not be met in a group home, so that residential habilitation is not an option for Michelle.

9. If Michelle's father and I were no longer able to provide for her care at home, Michelle would have to go to either an ICF/MR or a nursing facility because of her complex medical needs.

10. DDSN has determined each year that Michelle meets the eligibility requirements to live in an ICF/MR.

1

11. Michelle used to attend the Evergreen Skills workshop, but DDSN terminated this service several years ago telling us that they were unable to meet her needs at the workshop because of her feeding tube and the complexity of her care. They determined that it would not be safe for her to attend this facility

12. Michelle was assessed by the local adult day nursing program, but they refused to provide care for her there because of her feeding tube.

13. My husband and I have barely slept for the past two weeks because Michelle has not been sleeping at night and she has been having frequent seizures.

14. I am scheduled to have surgery on July 20, 2010 and I will not be able to provide care for Michelle during my recuperation.

15. We have repeatedly requested that DDSN provide respite at the Martha Franks Home, a nursing home in our community, so that we can have a break from caring for Michelle.

16. We are afraid for Michelle to receive respite or residential services in a DDSN ICF/MR because of the many "unexplained" injuries she had when she lived at the Whitten Center before she came home under the "Whatever It Takes" program.

17. I continue to read articles in the newspaper about abuse and neglect in DDSN residential programs, including the Whitten Center in Laurens County. See Exhibit 4.

18. A recent news report, which is attached, stated that the Whitten Center has settled three lawsuits in the past year.

19. A woman who lived in an ICF/MR operated by the Greenville DSN Board was recently found dead in a nearby church after leaving the facility.

20. DDSN previously paid for Michelle to receive respite services at Martha Franks, which is an approved Medicaid facility.

21. For several years, DDSN has told us that they cannot provide respite at Martha Franks because of budget reductions.

22. Michelle has received behavior support services from Lennie Mullis, who is an approved DDSN provider of behavior support services and we have been happy with the services she has provided.

23. Michelle's plan of care entry dated January 27, 2010 states that we have not been satisfied with Lennie's services, but that is not true.

24. I received a call about two weeks ago informing me that DDSN had terminated Lennie Mullis as a provider and asking if we wanted to use a different provider.

25. On March 24, 2009, DDSN approved Michelle receiving a generator so that her feeding pump could be continued during a power outage, but six months later, SCDDSN changed its mind and determined that Michelle did not meet the criteria for receiving a generator.

26. A Service Coordination Record of Contact dated December 29, 2009, which is signed by Laurens DSN Board employee, Jean Ramage, states that Michelle's family support stipend would be stopped because "there were state budget cuts and we not longer have any family support funds." Exhibit 5.

27. This stipend was not restored until after the article appeared in the Greenville News on January 1, 2010 and the Director of DDSN called me on New Year's Day to inform me that this stipend would be restored after the article was published. The article is attached as Exhibit 6.

28. When I requested a fair hearing to object to the reduction/terminations of Michelle's services, the South Carolina Department of Health and Human Services refused to give Michelle a hearing and dismissed her appeal. Exhibit 7.

29. The affidavit of Michelle's treating physician is attached as Exhibit 8. He determined that Michelle would likely have to return to an institution if her home-based services are reduced and he believes that her condition would deteriorate in an institution.

30. Dr. Patterson also stated that "She MUST have assistive personal care daily, and this has enabled her to have improved quality of life and to stay home with her parents who provide 24/7 care." He stated that decreasing her personal care services "is not in the patents best interest and will greatly increase her risk or needing hospitalization or institutionalization." Exhibit 9.

31. We have saved the State of South Carolina hundreds of thousands of dollars keeping Michelle at home and believe that forcing her into a more costly institution is not in her best interest or the best interest of state taxpayers.

I have read this statement and affirm that it is true, to the best of my knowledge. Executed on this 24 day of June, 2010.

Barbara Morgan
Barbara Morgan

SWORN TO BEFORE ME THIS
24 day of June, 2010

Notary Public for South Carolina
My Commission Expires: 01/10/2016

Exhibit 1

Affidavit of Barbara Morgan dated Jan 18, 2010

STATE OF SOUTH CAROLINA)
)
COUNTY OF LAURENS)
)

AFFIDAVIT OF BARBARA MORGAN

Now comes Barbara Morgan who swears and affirms that:

1. I am the parent of Michelle Morgan, who is 37 years old and has profound mental retardation, autism and a seizure disorder.

2. After I suffered a stroke, Michelle was admitted to the Whitten Center in the 1980's and she stayed there for about eight years.

3. About fifteen years ago, I received a call at 9:00 one night from the Whitten Center asking if we would remove Michelle from the facility and bring her home.

4. After that call, we attended a meeting with Dr. Judy Johnson, Dr. Chadwell and another employee of DDSN where they made a lot of promises to convince us to bring Michelle home from Whitten Center.

5. They told us that DDSN had a program called "~~What it Takes~~" "What will it Take" BM where they were promising services in order to reduce the population in ICF/MR programs.

6. We did not have heat throughout our house at the time and DDSN promised to do what it would take for Michelle to come home, including helping us rent a house that had heat, providing personal care services and respite.

7. In order for Michelle to come home,DDSN agreed to pay us a stipend of $525.00 a month to help pay Michelle's expenses at home.

8. Every few years, DDSN threatens to terminate this stipend, but each time, we have fought to require DDSN to keep its end of the bargain, because we cannot keep Michelle at home without this assistance.

9. After Michele had been back home for more than five years, DDSN asked us why we did not just put her back into an institution instead of keeping her at home. We have come to believe that Michelle would not be safe in a DDSN facility.

10. Michelle's health and mental state improved once she came home and it would be devastating to her to go back into an institution.

11. The last week in December, my husband received a call from the Laurens County DSN Board telling us that Michelle's $525.00 monthly stipend DDSN promised us when we brought her home from Whitten Center would be terminated immediately, but we never

received written notice that DDSN was terminating this stipend.

12. Dr. Judy Johnson was at the Whitten Center at the time that Michelle was there and she assured me that DDSN would provide this stipend and the services we needed to keep Michelle at home.

13. No one told me that there had been an investigation of abuse and neglect at the Whitten Center by the United States Department of Justice in the 1990's while Michelle was living there and that Ms. Johnson was involved in that investigation. Exhibit 1.

14. When Michelle was at the Whitten Center two of her teeth were knocked out and we were told that she "fell."

15. Michelle still has scars on her neck and side where she was clawed while she was living at Whitten Center.

16. Michelle broke her toe while living at the Whitten Center.

17. When she was living at the Whitten Center, Michelle's weight dropped to less than 80 pounds, but now she weighs 135 pounds.

18. When Michelle was living at the Whitten Center, she received treatment for depression, but she does not have depression now since she came home.

19. Michelle still does not sleep good and sometimes she will stay up at nights for five or six weeks at a time, keeping me from getting a good night's sleep.

20. Before January 1, 2010, the Medicaid waiver has paid for a PCA II (personal care assistant) who comes to our house at 8:00 a.m. for up to eight hours a day, but in December, DDSN informed us that they were going to reduce this service to no more than four hours a day, or 28 hours a week.

21. Michelle was receiving 28 hours a week of respite services at home, but the respite worker does not do the same tasks that the personal care assistant does. DDSN has offered to increase Michelle's respite services up to ~~30~~ 28 hours a week, but that does not take the place of the PCA hours Michelle has been receiving. BM. Before we filed our appeal, the service coordinator told us they would provide 30 hours respite.

22. Recently, I have been having trouble getting the supplies I need from the MR/RD waiver program to administer Michelle's tube feeding.

23. DDSN has not provided any nursing services to Michelle at home and they never informed me that she was entitled to receive nursing services, even though she is on a feeding tube for a large part of the day.

24. Michelle has to be watched closely during the day because she will try to get out of her geri-chair and her feeding tube will be pulled out.

25. My husband was recently hospitalized due to atrial fibrillation and congestive heart failure and he has an epidural because of back pain and he is not physically able to take care of Michelle's needs.

26. When Michelle came home, DDSN provided personal care services and respite services at the Martha Franke home in Laurens, which would give us respite for several days at a time, but these services were terminated several years ago because DDSN told us that they did not have funds to provide these services.

27. Every year at Michelle's annual plan meeting, I have asked for respite services so that Michelle's father and I can have a break for a few days or a week each year from our caregiving duties, but we have been informed that budget reductions prohibited us from receiving these services. (BM)

At our last, they took Michelle up for a week to Martha Franke, & when we had an emergency.

28. I did not receive a written notice until the end of December specifically informing us that DDSN was reducing Michelle's personal care services. Before that, all I received was a copy of the letter sent to all families of waiver participants and that letter assured us that there would be an exception for waiver participants who were "medically complex" or who had "severe disabilities." Exhibit 1.

29. I first received written notice of the reduction of Michelle's PCA services ~~later in~~ date (BM)

30 December ~~of~~ 2009 when DDSN sent a notice to the company that provides these services telling them that her PCA services would be reduced to 28 hours a week on January 1, 2010. Exhibit 2. ~~DDSN did not send me a copy of this notice;~~ (BM)

I received this notice after Michelle's services were cut.

30. When I asked Michelle's service coordinator how this change would affect Michelle, I was told that the reduction in Michelle's personal care services was "non-negotiable" and that we could not appeal the reduction of these services.

31. The reduction in Michelle's services was not based on her needs and her physician was never contacted by DDSN to find out how this would affect her health or her ability to remain out of an institution.

32. In December, a letter was sent to families served by the Laurens County DSN Board informing these families that people whose services were reduced could request an appeal, which was different from what I had been told before. Exhibit 3. We were told that we had 30 days to request an appeal. 3. BM

33. I asked Michelle's services coordinator to help me file an appeal, but she told me that she could not help me. She never told me that DDSN had a form you can fill out to request an appeal when services are reduced.

They are always pushing me to put Michelle at Whitten Center for (BM) her respite, but it is not an appropriate place for her.

34. I was led to believe by the Laurens DSN Board that it was too late then for me to appeal the reductions in Michelle's services, because more than ten days had passed since they sent out the generic letter to families saying that waiver services would be cut, but at that time we were led to believe that these cuts were "non-negotiable.".

35. Also, we did not believe that we could afford to appeal the reduction in Michelle's services because DDSN told families that they would have to pay for these services if they appealed and lost and we are already struggling to make ends meet now.

36. I did not learn until I contacted an attorney on new year's eve that DDSN could not charge families for waiver services if the participant's appeal is lost.

37. My husband and I are both sixty-six years old and we both have health problems and live on our Social Security benefits.

38. I never received an individual notice from DDSN informing me of the specific reductions that were being made until I received the notice later in December 2009, which DDSN sent to her provider of personal care services.

39. Most of the day, Michelle is hooked up to a feeding tube, but we get her up every few hours to go to the bathroom and to get some exercise.

40. Sometimes Michelle has toileting "accidents" and she wears diapers.

41. Michelle has not had any bedsores since she has been at home and BM no broken bones at home

42. Michelle has epilepsy and the medications BM she takes does not completely control her seizures. She takes a lot of medications to try and control her seizures.

43. At one time, Michelle was having more than a dozen seizures a day and most of these were grand mal seizures.

44. Sometimes, Michelle suddenly sits up in the bed at night and screams out and her physicians believe that this may be caused by seizure activity. This normally happens every other week and I get even less sleep on those nights.

45. Because Michelle is non-verbal, she cannot tell us whether she is having a seizure, but she jerks and turns to the side like she is having a seizure.

46. After we found out that Michelle's stipend was being cut, there was an article in the Greenville News about how the changes in the DDSN program were affecting the abiliity of families to keep their loved ones at home.

47. We were desperate about losing these services because Michelle would have to go into an institution if we do not get help keeping her home.

48. I talked with a reporter from the Greenville News on the afternoon of New Year's Eve and told reporter about our plight and our desire to keep Michelle at home and out of an institution.

49. Michelle's story was printed in the Greenville News on January 1, 2010. Exhibit #4. BM

50. I received a call from David Goodell at DDSN and the director of DDSN, Dr. Buscemi, late that same afternoon telling me that they were not going to reduce Michelle's $525 stipend after all, but DDSN still would not restore her personal care assistant services to the pre-January 1, 2010 level.

51. They did not tell me that Michelle's personal care services would be maintained if she filed an appeal or offer to help me file an appeal. We asked the service coordinator BM and she specifically told us she could not help us.

52. The threat to reduce Michelle's services has had an adverse effect on my health and it makes it harder for me to stay healthy enough to keep her at home.

53. My husband and I constantly worry that DDSN will call to tell us that they are again reducing Michelle's services or her stipend because they have repeatedly tried to violate the promises they made when we took Michelle out of the ICF/MR during the "~~What it Takes~~" program. BM
Will IT TAKE" BM

54. My biggest worry in life is that Michelle could have to go back to the Whitten Center because she is at risk of having to go back to an institution if her waiver services are cut.

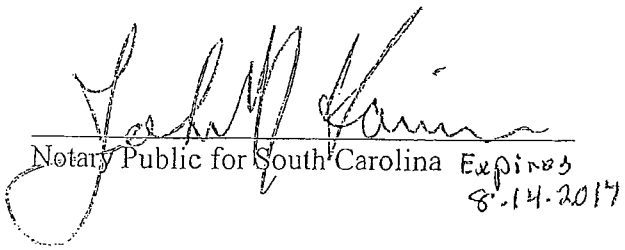
55. I do not believe that Michelle would be safe receiving respite services at the Whitten Center and I do not understand why DDSN will pay $270 a day for her to receive respite there, but they will not pay a lesser amount for her to receive respite in a faith-based nursing home that is certified by Medicaid.

56. Placing Michelle in an institution is the last thing we want to do, but it will be impossible to keep her at home if the proposed reductions are put into effect.

This affidavit is correct to the best of my knowledge. Executed this 18 day of January, BM 2010.

Barbara Morgan
Barbara Morgan, Parent of Michelle Morgan

Sworn to me this 18th day of January, 2010.



Notary Public for South Carolina Expires 8-14-2017

Exhibit 2
Letter Re: Thiry hours a week

Laurens County Disabilities and Special Needs Board

Phone: (864) 682-2314 Post Office Box 986, Laurens, South Carolina 29360 Fax: (864) 682-2397

May 26, 2010

To Whom It May Concern:

Kristin Wilson is currently employed as a respite caregiver for Michelle Morgan. At this time, Ms. Wilson works 30 hours per week.

Sincerely,

Monica Taylor

Monica Taylor
Finance Director

Administration	Evergreen Skills	Residential Services	Family Support Services
1860 Hwy 14	364 Evergreen Skills Rd.	1860 Hwy 14	314 Owings St.
Laurens, SC 29360	Laurens, SC 29360	Laurens, SC 29360	Laurens, SC 29360
Phone: (864)682-2314	Phone: (864)-682-5469	Phone: (864) 682-2314	Phone: (864) 984-0355
FAX: (864)682-2397	FAX: (864)682-8467	FAX: (864) 682-2397	FAX: (864) 984-8034

Supporting Unique People in Pursuing Opportunities while Reaching for a better Tomorrow

Exhibit 3

Plan of Care entry-only 2 additional hours approved

SERVICE COORDINATION REPORT FORM

1. **Focus Individual:** Michelle Morgan

2. **Date, Time, and Place of Contact:** 1/14/10, 1:45 PM

   - ☐ Telephone (with):
   - ☐ Community Meeting
   - ☐ Site Visit
   - ☐ Individual conference (with):
   - ☒ Other

3. **Staff Person(s) Making Contact:** Jean Ramage, DFSS

Nature of Contact (Please summarize what took place): Janet Prist (Central Office) contacted DFSS. Michelle Stone (SCS) witnessed call. She said that Central Office Executive Staff reconsidered the respite exception decision made by district staff. At this time, Michelle Morgan will receive 56 hours of PCAII and 30 hours of respite until a hearing appeal is requested and held. If they lose the appeal, her PCAII hours will be reduced back to 28 hours per week and Central Office approved to increase 56 hours of respite per week. This will happen after hearing. She advised us not to do anything until we heard from SCDDSN.

Jean Ramage, Director
Family Support Services

Cc: Jason Tavenner, ED

Exhibit 4

Care giver arrest report

News Channel 7 HD on your side
Spartanburg - Greenville - Anderson, SC - Asheville, NC

Tuesday, June 22, 2010 | Spartanburg, South Carolina 77° Feels Like: 77° Clear

NEWS

1-800-Flowers.com
1-Arrangement Florist
www.arrangementflorist.com

Former Caregiver Arrested

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By SHANA SMITH
Published: May 27, 2010

vote now

LAURENS, S.C. – A former South Carolina Department of Disabilities and Special Needs employee is arrested, accused of assaulting a mentally challenged, vulnerable adult, according to the South Carolina Law Enforcement Division.

Laloya Terria Bluford, 21, of Laurens is charged with assault and battery. According to a SLED warrant, Bluford assaulted a 29-year-old man by hitting him in the upper chest in August 2009. That man is a vulnerable adult in the care of the Whitten Center in Clinton. Agents say Bluford was employed as a caregiver at the facility.

The Whitten Center has settled three cases in the last year involving abuse.

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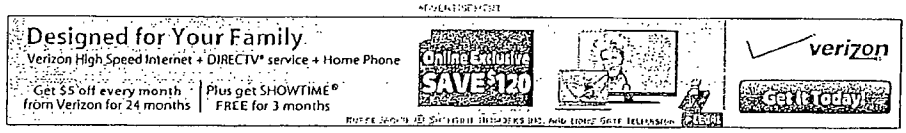

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SLED: Caregiver Hit Special Needs Patient

Latoya Terria Bluford Charged With Assault, Battery

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POSTED: 3:52 pm EDT May 27, 2010
UPDATED: 4:51 pm EDT May 27, 2010

Latoya Terria Bluford

CLINTON, S.C. -- A caregiver at the Whitten Center in Clinton has been charged with assaulting a patient.

The South Carolina Law Enforcement Division announced the arrest Thursday of former South Carolina Department of Disabilities and Special Needs employee, 21-year-old Latoya Terria Bluford, of Laurens.

Bluford is accused of assaulting a mentally challenged, vulnerable adult.

According to a SLED warrant, Bluford hit a 29-year-old male, vulnerable adult in the upper chest at the Whitten Center in August 2009.

Agents said Bluford was employed as a caregiver at the facility and the victim was a resident.

Bluford is charged with assault and battery (common law).

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Exhibit 5

Service Coordination Records of Contact

SERVICE COORDINATION RECORD OF CONTACT

Focus Person: Michelle Morgan
Type of Contact: Telephone
Date of Contact: 12/29/09

DFSS contacted Mr. Morgan regarding Michelle's family support stipend ending. DFSS informed him that there were state budget cuts and we no longer have any family support funds. He told DFSS that they had been promised this many years ago when Dr. Chaldwell and carol Martin worked at Whitten Center. He requested Carol Martin's number. DFSS informed him she had retired. DFSS did give him John King's number at Central office.

Jean Ramage
Director of Family Support Services

RECORD OF CONTACT

DATE: December 31, 2009

CONSUMER: Michelle Morgan

TYPE OF CONTACT: Other

SERVICE COORDINATOR'S SIGNATURE: Jane Powers, SC

On 12/22, SC prepared the usual six months' Family Support Stipend request form and forwarded to DFSS Ramage for approval. Today SC received the form back noting that the request has been denied because no Family Support funds are available after the last round of budget cuts. DFSS Ramage informed SC that she had called Michelle's home on 12/29 and talked with Mr. Morgan, telling him the news about the monthly stipend being discontinued. She said that she had advised him to talk with John King, regional administrator. She said that she was in Jason Tavenner's (Executive Director) office this morning when he called and talked with Mrs. Morgan. Mrs. Morgan told him that she had talked with John King, who told her to call Jason. Jason informed Mrs. Morgan that if central office gave the Laurens Board the money, the stipend would be reinstated.

RECORD OF CONTACT

DATE: January 4, 2010

CONSUMER: Michelle Morgan

TYPE OF CONTACT: Other

SERVICE COORDINATOR'S SIGNATURE: Jane Powers, SC

SC was informed by DFSS Ramage that she had been instructed by ED Jason Tavenner to reinstate the services Michelle was receiving prior to December 31. (ED Tavenner had talked with someone in central office and also with Patricia Harrison, lawyer for a group of consumers which now includes Michelle.) SC prepared an authorization form for PCII authorizing the original 224 units (7 days per week, 8 hours per day) per week. SC faxed the authorization to Donna Hughes, RN, Caring Hands. SC updated Michelle's plan once again. SC called Michelle's home and got their answering machine. SC left a message for Mrs. Morgan to call her.

Exhibit 6

Greenville News Article dated January 1, 2010

SO MUCH HAPPENED BEFORE DOROTHY

Disabled to lose services as Supreme Court rejects motion

BY LIV OSBY • HEALTH WRITER • JANUARY 1, 2010

(2 of 2)

The lawyers said the claim that many people stand to be institutionalized is "grossly overstated," and that DDSN isn't aware of anyone likely to be institutionalized because of the changes.

They also said the changes constitute no immediate harm to the clients named in the suit, or to anyone else, that would require immediate relief.

Barbara Morgan of Laurens said she doesn't know how her family will manage now that personal care services for her disabled daughter Michelle will be cut from eight to four hours a day.

She said she was notified this week that a $525 monthly stipend from the state to keep Michelle, 37, at home and out of an institution, will be eliminated as well. Now, she said, she and her husband, both 66 and in ailing health, will have to cut living expenses.

"My husband said we'd have to cut down on the power bill and heat," she said.

Agency commissioner Rick Huntress of Greenville told *The Greenville News* earlier this week that

Homeowners Fail to Refinance
Take advantage of Obama's Refinance Plan. Calculate new Payment...
Get details...

Obama Raises Pell Grants
Get Your Degree Now. Financial Aid & Scholarships are available.
More info...

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Kevin S
Man's I
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Clemsc
Former
Cubs
Funera
at 1 p.r

Penny stocks can jump 5000% Join Today for Free to Profit.
Get details...

Exploding Penny Stocks
800% Penny Stock Gains! Don't Miss This Great Opportunity.
Explore more...

commissioners repeatedly have asked that stimulus money be restored to the agency, though he wasn't familiar with the "excess" money the suit alleges the agency had.

And agency officials have said that service reductions were necessary because of budget cuts, but that they might not have been needed if the Legislature had allowed the agency to keep more of the stimulus funds for which it qualified.

Previous Page 1 | 2

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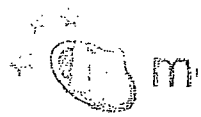

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Exhibit 7

Order dismissing case

RECEIVED MAY 2 7 2010

South Carolina Department of
Health & Human Services

Emma Forkner Director
Mark Sanford Governor

May 17, 2010

CERTIFIED MAIL

Patricia L. Harrison, Esquire
611 Holly Street
Columbia SC 29205

RE: Order of Dismissal in the Appeal Matter of Michelle Morgan v. SCDHHS
Appeals' Case # 10-MISC-053 (MR/RD Waiver)

Dear Ms. Harrison, Esquire:

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)

cc: Dr. Kathi Lacy, Ph.D., Associate State Director, Policy, SCDDSN
Kara Lewis, Bureau of Community Long Term Care Services, SCDHHS
Office of General Counsel, SCDHHS
Richard Hepfer, Deputy General Counsel, SCDHHS

71. Filing Fee.

A. Cases for which Fee Required. Each request for a contested case hearing, notice of appeal, or request for injunctive relief before the Court must be accompanied by a filing fee in the amount set forth in Rule 71(C). A case will not be assigned to an iinistrative law judge and will not be processed until the filing fee has been paid or a waiver has been granted pursuant to Rule 71(B). This fee is not required for contested cases, appeals, or requests for injunctive relief brought by the State of South Carolina or its departments or agencies. For appeals brought pursuant to Al-Shabazz v. State, 338 S.C. 354, 527 S.E.2d 742 (2000), the fee will be assessed only for the seventh and subsequent appeals filed by an inmate during a given calendar year.

27

B. Request for Waiver. A party who is unable to pay the filing fee may request a waiver of the fee by filing a completed Request for Waiver form with the Clerk of the Court at the same time the request for a contested case, notice of appeal, or request for injunctive relief is filed with the Court. Request for Waiver forms shall be issued by the Clerk of the Court. If the filing fee is not waived, the party must pay the filing fee within ten days of the date of receipt of the order denying waiver of the filing fee. If the filing fee for a case is waived on behalf of a party, any motions filed by that party in that case are exempt from the motion fee as provided in Rule 71(D).

C. Schedule of Filing Fees. The filing fee will be assessed according to the following schedule:

Case Type
Fee

Dept. of Health and Human Services
$50

D. Motion Fees. A fee of $25 will be imposed for the following motions filed with the rt:

1) Motion for Summary Judgment
2) Motion to Intervene
3) Motion to Dismiss
4) Motion for Injunctive Relief (in a pending case).
5) Motion to Compel

The fee must be submitted to the Clerk of the Court at the same time the motion is filed, unless a waiver of the filing fee in the case was previously granted to the party filing the notion. A motion will not be deemed filed until the fee is paid. The motion fee is not required for motions filed by the State of South Carolina or its departments or agencies.

2009 Revised Notes

Rule 71 provides for a schedule of filing fees as authorized by law. The filing fee varies according to the type and complexity of the case. The fee is required for all requests for a contested case hearing, notices of appeal, or requests for injunctive relief except for those brought by the State of South Carolina or its departments or agencies. For those appeals brought pursuant to Al-Shabazz v. State, 338 S.C. 354, 527 S.E.2d 742 (2000), the fee applies only to the third and subsequent filings by an inmate during a given calendar year. If a party is unable to pay the filing fee, he may request a waiver of the fee by filing the prescribed form with the Clerk of the Court. A case will not be assigned to an administrative law judge until the filing fee has been received or a waiver has been granted. Subsection (D) provides for a twenty-five dollar motion fee for certain motions filed with the Court. A motion will not be deemed filed with the Court until the fee has been paid. However, the motion fee is not required for motions filed by the State of South Carolina or its departments or agencies. In addition, if a party is granted a waiver of the filing fee, any fees for motions filed by that party are likewise waived.

RULING ON RESPONDENT'S MOTION TO FILE LATE RETURN OF COMMENTS ON PETITIONER'S INTERLOCUTORY ORDER RESPONSE AND ORDER OF DISMISSAL IN THE APPEAL MATTER OF M.M. (PETITIONER) v. SCDHHS (RESPONDENT)

Appeals' Case #10-MISC-053 (MR/RD)
Hearing date: Not held

JURISDICTION

Procedure in this case is governed under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services to administer various programs and grants (See e.g., S.C. Code Ann. 44-6-10, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (Reg. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. 1-23-310, et seq.).

STATEMENT OF THE CASE

The Petitioner receives Mental Retardation and Related Disabilities (MR/RD) Waiver Medicaid benefits. Via letter of January 13, 2010 Beverly Buscemi, Ph.D., State Director of the Respondent's agent, South Carolina Department of Disabilities and Special Needs (SCDDSN) notified the Petitioner's attorney, Patricia Harrison that SCDDSN was upholding its determination to reduce the Petitioner's Personal Care 2 (PC-2) services to the Petitioner from fifty-six (56) hours per week to twenty-eight (28) hours per week due to changes in the MR/RD Medicaid Waiver. Via letter of February 11, 2010 Ms. Harrison appealed the reduction of PC-2 services to the Petitioner under the MR/RD Medicaid Waiver.

ISSUE

The immediate determinative issue in this matter is whether the Respondent, South Carolina Department of Health and Human Services (SCDHHS) and its agent, South Carolina Department of Disabilities and Special Needs (SCDDSN) properly decreased the Petitioner's Personal Care 2 (PC-2) services to twenty-eight (28) hours per week under the MR/RD Medicaid Waiver program due to changes in the MR/RD Medicaid Waiver. Any issues raised in the proceedings or hearing of this case but not addressed in this Decision are deemed denied.

SUMMARY OF THE EVIDENCE AND ARGUMENTS

Petitioner's Evidence and Arguments:

(1) The Petitioner's attorney, Patricia Harrison asserts the SCDHHS Division of Appeals and Hearings is prohibited from dismissing the Petitioner's appeal without a hearing because the South Carolina Code of Regulations, Chapter 126-154 exceeds the authority granted to the SCDHHS Division of Appeals and Hearings by 42 U.S.C. §1396(a)(3) and applicable regulations, *Goldberg v. Kelly*, the Fourteenth Amendment of the United States Constitution, and the Supremacy Clause of the United States Constitution.

(2) Ms. Harrison asserts any authority the Respondent, SCDHHS has to establish its policies and procedures for administering the South Carolina Medicaid program are preempted by §1396 et seq. of the Social Security Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, the American Recovery and Reinvestment Act (ARRA), and the Supremacy Clause of the United States Constitution.

(3) Ms. Harrison asserts the Respondent has violated the Petitioner's rights under the ARRA by diverting funds the United States Congress intended to be used to maintain services to the Petitioner and to preserve the jobs of her caregivers.

(4) Ms. Harrison asserts the Respondent has violated South Carolina Code of Laws §44-6-70(b) which requires the Respondent to provide the most appropriate care, tailored to the Petitioner's needs and delivered in the most cost-effective manner.

(5) Ms. Harrison asserts the Respondent has violated South Carolina Code of Laws §44-6-70(f) by implementing changes to the MR/RD Medicaid Waiver based on a pretext of budget reductions when the real purpose of the changes was to eliminate services afforded by private and faith-based providers while maintaining band payments to local Disabilities and Special Needs (DSN) Boards.

(6) Ms. Harrison asserts the Respondent has violated South Carolina Code of Laws §44-6-40 by failing to deliver services and to administer plans in the most effective and efficient ways possible, and South Carolina Code of Laws §44-6-80 by failing to inform the South Carolina General Assembly prior to making substantial changes in the MR/RD Medicaid Waiver program.

(7) Ms. Harrison asserts the Respondent violated South Carolina Code of Laws §44-6-132 by failing to use State funds to take advantage of Federal funds, instead using funds allocated by the South Carolina General Assembly and "client fees" to purchase real estate for DSN Boards which compete with private providers.

(8) Ms. Harrison asserts the Governor of South Carolina, Mark Sanford and the Director of SCDHHS, Emma Forkner have been placed on notice by one or more SCDDSN Commissioners and the former internal auditor of SCDDSN about the misuse of funds by SCDDSN, and Governor Sanford and SCDDHS Director Forkner have failed to take appropriate action to hold SCDDSN accountable for the expenditure of Medicaid funds in violation of the Medicaid Act. In addition, these misused funds have been used to provide congregate services where the Petitioner is segregated from the community, thus reducing funds available to provide services to the Petitioner in her home.

(9) Ms. Harrison asserts the Respondent has encouraged the monopoly of DSN Boards in violation of State and Federal laws, thereby reducing the choice of providers available to the Petitioner, in an attempt to force the Petitioner into institutional day or residential services provided by SCDDSN and its DSN Boards.

(10) Ms. Harrison asserts the Respondent's reduction of PC-2 services places the Petitioner's health and welfare at risk, in violation of the Medicaid Act. In addition, the reduction of PC-2 services violates the Medicaid Act as the Medicaid Act requires the Respondent to provide waiver services in the amount, duration, and scope necessary to comply with the purpose of the Home and Community Based Waiver Program, which is to prevent the institutionalization of the Petitioner.

(11) Ms. Harrison asserts the Respondent's reduction of PC-2 services to the Petitioner and the failure to authorize the maximum number of Respite Services hours violate the ADA, the ruling of the United States Supreme Court in *Olmstead v. L.C.*, Section 504 of the Rehabilitation Act, and the ARRA.

(12) Ms. Harrison asserts the Petitioner was adversely affected by the Respondent's elimination of speech and language services, speech therapy, physical therapy, and occupational therapy from the MR/RD Medicaid Waiver and that the Petitioner did not receive notice of the termination of these services.

(13) Ms. Harrison asserts the Respondent's reduction of MR/RD Waiver Medicaid services was arbitrary and not based on medical necessity or any determination by the Petitioner's treating physician, which violates the Medicaid Act, ADA, and Section 504 of the Rehabilitation Act.

(14) Ms. Harrison asserts the Respondent's reduction of waiver services while increasing institutional respite reimbursement rates by 70% was not based on reasonable standards and is not in the best interest of the MR/RD Medicaid Waiver recipients, as required by the Medicaid Act.

(15) Ms. Harrison asserts the Respondent and its agent, SCDDSN have failed to inform the Petitioner of all feasible alternatives under the MR/RD Medicaid Waiver which would allow her to remain in the least restrictive setting.

Respondent's Evidence and Arguments:

(1) Richard Hepfer, SCDHHS Deputy General Counsel asserts 42 CFR §431.200 et seq.; Goldberg v. Kelly, 397 U.S. 254 (1970); Rosen v. Goetz 410.F. 3d 919 (6th Cir. 2005); Matthews v. Eldridge, 424 U.S. 319 (1976); Mims v. SCDHHS, Docket No. 07-ALJ-08-0082-AP (Adm. Law Crt. 2007); and Sunset Cay, LLC v. City of Folly Beach, 357 S.C. 414, 593 S.E.2d 462 (2004) do not require the SCDHHS Division of Appeals and Hearings to afford an evidentiary hearing to each and every Petitioner who appeals an SCDHHS decision.

(2) Mr. Hepfer asserts Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999) dealt with deinstitutionalization of individuals who wanted to be integrated into community living; therefore, since the Petitioner is already living in the community this case is not applicable to the Petitioner's appeal, and it is speculative at best to assume that the Petitioner's reduction in services will lead to her institutionalization. However, even if the Petitioner does experience difficulty in the future, Olmstead directed that "[t]he State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless,"

(3) Mr. Hepfer asserts regardless of who determines the "medical necessity" for the Petitioner's MR/RD Waiver services, i.e., the Petitioner's treating physicians or SCDHHS, the issue of medical necessity does not override the SCDHHS programmatic limits on the services.

(4) Mr. Hepfer asserts the American Recovery and Reinvestment Act (ARRA) directed that in order for States to receive increased Federal Medical Assistance Percentages (FMAPs) for State expenditures such as Medicaid, the State may not restrict eligibility "standards, methodologies, or procedures" beyond those in effect on July 1, 2008. Since the changes to the MR/RD Medicaid Waiver only affected services, the restrictions of ARRA do not apply in this matter.

(5) Mr. Hepfer asserts Petitioner's attorney's allegations of misuse of State funds were raised in a Petition for the South Carolina Supreme Court to take original jurisdiction and grant an injunction against SCDHHS' and SCDDSN's imposition of the Waiver limitations. Mr. Hepfer states that the South Carolina Supreme Court denied the Petition and declined to grant the injunction, and there has been recently filed a similar action for similar relief in the Federal District Court of South Carolina; therefore, as a matter of comity, the SCDHHS Division of Appeals and Hearings should defer to the District Court for resolution of these issues.

(6) Mr. Hepfer asserts six (6) statewide workshops were held in September and October 2009 preceding the MR/RD Medicaid Waiver reduction in services and the purpose of these workshops was to alert the public to the proposed changes. Mr. Hepfer states that on December 1, 2009 a general notice was sent out to all SCDDSN clients notifying them of the pending changes and urging them to work closely with their SCDDSN Service

Coordinators to mediate the impact of the new service limits. Later in December 2009 specific notices were sent to the recipients who were directly impacted.

(7) Mr. Hepfer asserts South Carolina Code of Laws §44-6-40 describes the duties of SCDHHS as to administer the Federal plans under its control guided by the goal of "...administering the plans in the most effective and efficient way possible."

(8) Mr. Hepfer asserts South Carolina Code of Laws §44-6-70 deals with the preparation of the State Plan and directs SCDHHS to consider objectives of seeing that "...appropriate care is given, tailored to the client's needs, it is delivered in the most cost-effective manner...and "...maximiz[ing] utilization of private and nonprofit providers..." Mr. Hepfer states that Waivers operate outside of the State Plan but follow general Medicaid rules unless they are "waived" and that Waivers, by their nature are required to meet cost-effectiveness standards set forth in 42 CFR §441.300 et seq.

(9) Mr. Hepfer asserts South Carolina Code of Laws §44-6-80 requires SCDHHS to submit an annual report.

(10) Mr. Hepfer asserts South Carolina Code of Laws §44-6-132 sets forth the legislative findings and intent with respect to the Medically Indigent Assistance Program, which is operated outside of the South Carolina Medicaid Program.

APPLICABLE LAW

(1) Rule 61 of the South Carolina Rules of Civil Procedure discusses harmless error and reads as follows:

"No error in either the admission or the exclusion of evidence and no error or defect in any ruling or order or in anything done or omitted by the court or by any of the parties is ground for granting a new trial or for setting aside a verdict or for vacating, modifying or otherwise disturbing a judgment or order, unless refusal to take such action appears to the court inconsistent with substantial justice. The court at every stage of the proceeding must disregard any error or defect in the proceeding which does not affect the substantial rights of the parties."

(2) 42 CFR §430.25(b) discusses the purpose of State Medicaid Waivers and reads as follows:

"(b) Purpose of waivers. Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on

a time-limited basis, and subject to specific safeguards for the protection of recipients and the program. Detailed rules for waivers are set forth in subpart B of part 431, subpart A of part 440, and subpart G of part 441 of this chapter."

(3) 42 CFR §440.180 allows State Medicaid agencies to provide services that are not otherwise furnished under the State Medicaid Plan. Paragraph (b) of this section lists the services that SCHHHS may include in the MR/RD Waiver and reads as follow:

"(b) Included services. Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:
(1) Case management services.
(2) Homemaker services.
(3) Home health aide services.
(4) Personal care services.
(5) Adult day health services.
(6) Habilitation services.
(7) Respite care services.
(8) 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, subject to the conditions specified in paragraph (d) of this section.
(9) Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization."

(4) 42 CFR §441.300 describes the purpose of a Medicaid Waiver and reads as follows:

"Sec. 441.300 Basis and purpose.

Source: 46 FR 48541, Oct. 1, 1981, unless otherwise noted.

Section 1915(c) of the Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. Those services are defined in Sec. 440.180 of this subchapter. This subpart describes what the Medicaid agency must do to obtain a waiver."

(5) 42 CFR §441.301 directs the State Medicaid agencies with regard to what they must include in their request for any Waiver, including South Carolina's MR/RD Medicaid Waiver. The request for any Waiver must describe the services to be furnished so that each service is separately defined.

(6) Before CMS granted the MR/RD Waiver to SCDHHS, SCDHHS had to prove to CMS that it would safeguard the health and welfare of all MR/RD Medicaid Waiver recipients as stated in 42 CFR §441.302, which reads as follows:

"Sec. 441.302 State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted:
(a) Health and Welfare--Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include--
(1) Adequate standards for all types of providers that provide services under the waiver;
(2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and
(3) Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities."

(7) 42 CFR §441.302(d) directs SCDHHS with regard to what the eligible recipient must be informed of when the recipient is found eligible for the MR/RD Medicaid Waiver and reads as follows:

"(d) Alternatives--Assurance that when a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be--
(1) Informed of any feasible alternatives available under the waiver; and
(2) Given the choice of either institutional or home and community-based services."

(8) 42 U.S.C §1396a(a)(3) directs each State Medicaid agency with regard to its granting of an opportunity for a fair hearing and reads as follows:

"(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;"

(9) 42 CFR §431.200(b) further directs the State Medicaid agency when it reduces services to recipients and reads as follows:

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

(10) 42 CFR §431.205 instructs the State Medicaid agency with regard to its fair hearing system and reads as follows:

"Sec. 431.205 Provision of hearing system.

(a) The Medicaid agency must be responsible for maintaining a hearing system that meets the requirements of this subpart.
(b) The State's hearing system must provide for--
(1) A hearing before the agency; or
(2) An evidentiary hearing at the local level, with a right of appeal to a State agency hearing.
(c) The agency may offer local hearings in some political subdivisions and not in others.
(d) The hearing system must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970), and any additional standards specified in this subpart."

(11) 42 CFR §431.220 further directs the State Medicaid agency with regard to granting fair hearings and reads as follows:

"Sec. 431.220 When a hearing is required.
(a) The State agency must grant an opportunity for a hearing to the following:
(1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness.
(2) Any recipient who requests it because he or she believes the agency has taken an action erroneously.
(3) Any resident who requests it because he or she believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged.
(4) Any individual who requests it because he or she believes the State has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act.
(5) Any MCO or PIHP enrollee who is entitled to a hearing under subpart F of part 438 of this chapter.
(6) Any PAHP enrollee who has an action as stated in this subpart.
(7) Any enrollee who is entitled to a hearing under subpart B of part 438 of this chapter.
(b) 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."

(12) The South Carolina Code of Regulations §126-154 grants authority to SCDHHS Hearing Officers and reads as follows:

"126-154. Hearing Officer.

A Hearing Officer has the authority, among other things to: direct all procedures; issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or proposed findings of fact and conclusions of law; call witnesses and cross-examine any witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with requirements under this Subarticle."

(13) Every court has the power and duty to determine whether or not it has jurisdiction of a cause presented to it for determination. Bridges v. Wyandotte Worsted Co., 243 S.C. 1, 8, 132 S.E.2d 18, 21 (1962), overruled in part on other grounds by Sabb v. S.C. State Univ., 350 S.C. 416, 567 S.E.2d 231 (2002). Accordingly, the lack of subject matter jurisdiction can be raised at any time, can be raised for the first time on appeal, and can be raised sua sponte by the court. Lake v. Reeder Constr. Co., 330 S.C. 242, 248, 498 S.E.2d 650, 653 (Ct. App. 1998).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After careful consideration of the entire record, I make the following findings by a preponderance of the evidence:

(1) The Petitioner receives MR/RD Medicaid Waiver Services (Petitioner's exhibit #1).

(2) Via letter of January 13, 2010 Beverly Buscemi, Ph.D., State Director of the Respondent's agent, South Carolina Department of Disabilities and Special Needs (SCDDSN) notified the Petitioner's attorney, Patricia Harrison that SCDDSN was upholding its determination to reduce the Petitioner's Personal Care 2 (PC-2) services to the Petitioner from fifty-six (56) hours per week to twenty-eight (28) hours per week due to changes in the MR/RD Medicaid Waiver (Petitioner's exhibit #1).

(3) Via letter of February 11, 2010 the Petitioner's attorney, Patricia Harrison appealed the Respondent's "reductions of MR/RD Medicaid Waiver services of [Petitioner's name redacted] and the elimination or reduction of the availability of nutritional supplies, Occupational Therapy, Physical Therapy and daily respite services." In addition Ms. Harrison appealed the reduction of other services (Petitioner's exhibit #2).

(4) Via Interlocutory Order (Cause of Action) this Hearing Officer directed Ms. Harrison to state a legitimate cause of action (error of fact or law), in writing and provide supporting documentation, on or before March 18, 2010 [Hearing Officer's (HO) exhibit #1].

(5) On March 18, 2010 Ms. Harrison filed her response to this Hearing Officer's Interlocutory Order (Petitioner's exhibit #3).

(6) Via Memorandum of March 18, 2010 this Hearing Officer directed Kara Lewis, Waiver Coordinator in the SCDHHS Community Long Term Care Division to review Ms. Harrison's response to this Hearing Officer's Interlocutory Order and to file any comments before April 6, 2010 (HO exhibit #2).

(7) On April 6, 2010 Richard Hepfer, Esquire, SCDHHS Deputy General Counsel filed his comments and a Motion to File a Late Return. Mr. Hepfer asserted that he misread the Hearing Officer's March 18, 2010 Memorandum and that the late return of one (1) day is an inconsequential delay in processing the case and will not prejudice the Petitioner in any way (Respondent's exhibit #3).

---*Conclusion of Law: Respondent's counsel's one (1) day late filing of his comments to Petitioner's counsel's Response to this Hearing Officer's Interlocutory Order is harmless error and will not affect the substantial rights of the Petitioner pursuant to Rule 61 of the South Carolina Rules of Civil Procedure.*

(8) The Federal Centers for Medicare and Medicaid Services (CMS) renewed the Respondent's MR/RD Medicaid Waiver effective January 1, 2010. As stated in this Waiver, its purpose is to permit the South Carolina Medicaid agency (SCDHHS) to furnish an array of home and community-based services that assist Medicaid recipients to live in the community and avoid institutionalization. SCDHHS 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. 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 (Respondent's Application for a §1915(c) Home and Community-Based Services Waiver, Approved Effective Date 01/01/10).

(9) The renewed MR/RD Medicaid Waiver effective January 1, 2010 did implement changes to the previous Waiver and these changes reduced the maximum number of Personal Care 2 (PC-2) Services that an MR/RD Medicaid Waiver recipient could receive to twenty-eight (28) hours per week (Respondent's Application for a §1915(c) Home and Community-Based Services Waiver, Approved Effective 01/01/10).

(10) The only change in services that affected the Petitioner after the MR/RD Medicaid Waiver was renewed effective January 1, 2010 is a reduction from fifty-six (56) hours per week to twenty-eight (28) hours per week of PC-2 services (Petitioner's exhibit #1, Respondent's exhibits #1 and #3).

(11) The reduction of the Petitioner's PC-2 hours to twenty-eight (28) hours per week was a reduction applied to all South Carolina MR/RD Medicaid Waiver recipients (Respondent's Application for a §1915(c) Home and Community-Based Services Waiver, Approved Effective 01/01/10).

---Conclusion of Law: The Petitioner was granted an opportunity for a hearing pursuant to 42 CFR §431.220(a).

---Conclusion of Law: Petitioner's counsel has appealed the Respondent's reduction of services in the renewed MR/RD Medicaid Waiver; however, the only service that was reduced to the Petitioner was PC-2 services. Petitioner's counsel cannot appeal a reduction of services that the Petitioner was not receiving. 42 CFR §431.200(b)

---Conclusion of Law: Petitioner's counsel raised many broad, global complaints against SCDHHS, SCDDSN, and the Governor of South Carolina with regard to how Federal and State money was misspent and how this misspending caused the MR/RD Medicaid Waiver reduction of services; however, this Hearing Officer does not have the authority to hear these complaints. 42 CFR §431.220

---Conclusion of Law: Petitioner's counsel asserts that the reduction of PC-2 services to the Petitioner aggrieved the Petitioner in several ways and that these reductions do not comply with the purpose of the MR/RD Medicaid Waiver. These arguments do not address the underlying issue, does the Respondent have the authority to establish these reductions with CMS approval. Therefore, these arguments are without merit. 42 CFR §441.301 allows the Respondent to set service limits on the MR/RD Medicaid Waiver with CMS approval.

---Conclusion of Law: The sole issue in this matter involves the Respondent's authority to set and change its Medicaid policy, specifically in this case to change the services that the recipients in the MR/RD Medicaid Waiver receive. The Petitioner's counsel has failed to prove that the Respondent does not have that authority; therefore, this matter is properly subject to dismissal as the Petitioner's counsel has failed to state a legitimate Cause of Action for her appeal. 42 CFR §431.220(b), South Carolina Code of Regulations §126-154

---Conclusion of Law: The SCDHHS Division of Appeals and Hearings has no jurisdictional authority in this matter; therefore, this matter is properly subject to dismissal. 42 CFR §431.220(b), South Carolina Code of Regulations §126-154

ANALYSIS/DISCUSSION

(A) Petitioner's counsel asserts Goldberg v Kelly, 397 U.S. 254 (1970); 42 U.S.C. §1396(a)(3) and applicable regulations; the Fourteenth Amendment of the United States Constitution; and the Supremacy Clause of the United States Constitution requires that this matter be adjudicated through the SCDHHS administrative hearing process. 42 U.S.C. §1396(a)(3) does direct the SCDHHS to provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

this opportunity has been granted to the Petitioner. The Code of Federal Regulations (CFR) acts as a type of procedures manual that further explains the intent of the United States Code of Laws. 42 CFR §431.205 does require the State Medicaid agencies to maintain a fair hearing system that meets the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970), and any additional standards specified in 42 CFR Part 431, Subpart E. The additional standards found in 42 CFR Part 431, Subpart E, Section 220(b) instruct the State Medicaid agencies that they 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. CMS has allowed SCDHHS to change the limits on certain services offered pursuant to 42 CFR §441.301, in the purely optional MR/RD Medicaid Waiver, i.e., this Waiver is not a program that the Federal government requires SCDHHS to offer in order to administer the South Carolina Medicaid program. In an attempt to control costs in a State with incredible overall State budget reductions, SCDHHS has elected not to eliminate programs but to place limits on services that are offered to all MR/RD Medicaid Waiver recipients. Section 1 of the Fourteenth Amendment states that no State shall deprive any person of life, liberty, or property, without due process of law. The Petitioner has received adequate notice that her PC-2 services were being reduced to twenty-eight (28) hours per month and her attorney properly filed for a reconsideration of that determination. Via letter of January 13, 2010 the Respondent notified the Petitioner's attorney that the determination was upheld and the Petitioner's attorney filed her appeal of the reconsideration determination on February 16, 2010. The Petitioner's attorney has been given the opportunity to inform this Hearing Officer of an error of fact or law made by the Respondent when reducing the Petitioner's PC-2 services and the Petitioner's attorney has taken advantage of that opportunity. I find that the Petitioner has been afforded due process of law; however, there is no relief that I could possibly grant the Petitioner through an evidentiary hearing as I do not have the authority to grant dispensation of MR/RD Medicaid Waiver service limitations. Simply put, the Supremacy Clause of the United States Constitution means that Federal Law will preempt State Law. In the Petitioner's case, 42 CFR §431.220(b) instructs the State Medicaid agencies that they 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; therefore, this Code of Federal Regulations Section does not require me to hold an evidentiary hearing in this matter.

(B) Petitioner's counsel asserts the Respondent's reduction of PC-2 services to the Petitioner and the failure to authorize the maximum number of Respite Services hours for the Petitioner violate Olmstead v L.C. ex rel. Zimring, 527 U.S. 581 (1999). First, Petitioner's counsel has not stated that the Petitioner has requested more Respite Services hours and SCDDSN has denied that request, in fact, Petitioner's counsel has not denied SCDDSN's assertion that the only change placed upon the Petitioner was a reduction in the number of PC-2 services; therefore, this is a meaningless argument. The Petitioner and/or her representative certainly have some responsibility to inform the Respondent's agent, SCDDSN if more Respite Services are needed. Second, with regard to the reduction of PC-2 services, Olmstead considered whether the prohibition of discrimination requires placement of individuals with mental disabilities in community settings rather than in institutions, if the individuals could reasonably be expected to live safely in a

community setting. As stated by Respondent's counsel, Olmstead found "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." As stated in (A) above, the reduction of PC-2 services to a maximum of twenty-eight (28) hours per month to all MR/RD Medicaid Waiver recipients is an attempt to control costs in a State with incredible overall State budget reductions; therefore, I find that the Respondent's reduction of services is exactly what is contemplated by Olmstead, that is, to renew the Petitioner's PC-2 services to prior levels would be inequitable, given SCDHHS' responsibility to all Medicaid recipients in the State. In addition, I find that to not limit some services risks entire Medicaid programs being eliminated in South Carolina in order to deal with the State's significant budget reductions.

(C) Petitioner's counsel asserts the Respondent's reduction of PC-2 services violates the Americans with Disabilities Act of 1990. Nowhere in this Act is a State Medicaid agency prohibited from providing Medicaid services which are jointly funded through Federal and State funds, within the very broad framework found within Title 42 of the Code of Federal Regulations; therefore, I find this argument without merit as SCDHHS as acted within its authority based on Title 42 of the Code of Federal Regulations.

(D) Petitioner's counsel asserts the Respondent's reduction of PC-2 services violates Section 504 of the Rehabilitation Act of 1973. Section 504 of the Rehabilitation Act of 1973 did protect disabled individuals from being discriminated against by not being allowed to receive program benefits and services by organizations that receive financial assistance from any Federal agency; therefore, this Act certainly applies to SCDHHS and the Medicaid services that it provides. In this instance, the Petitioner is not being denied the opportunity to participate in or benefit from a federally funded program, the MR/RD Medicaid Waiver; instead, she is being made to recognize the maximum PC-2 limit that every other recipient in the Waiver is being made to recognize. I do not find this to be discrimination but simply an unfortunate occurrence mandated by South Carolina's severe budget reductions which has forced SCDHHS to reduce services so that it can operate all Medicaid programs in an efficient and cost-effective manner pursuant to 42 CFR §430.25(b)

(E) Petitioner's counsel asserts the Respondent's reduction of PC-2 services to the Petitioner violates the American Recovery and Reinvestment Act of 2009 (ARRA). Section 5001(f)(1) of the ARRA mandated that States could not make their eligibility standards, methodologies, or procedures more restrictive than were in effect on July 1, 2008, if those States wished to be eligible for an increase in their Federal Medical Assistance Percentages (FMAPs). The ARRA did not prevent States from reducing services in their programs; therefore, this argument is without merit.

(F) Petitioner's counsel asserts the Respondent's reduction of PC-2 services place the Petitioner's health and welfare at risk, in violation of the Medicaid Act and does not

provide Waiver services in the amount, duration, and scope necessary to comply with the purpose of the Home and Community Based Waiver Program, which is to prevent the institutionalization of the Petitioner. First, with regard to the health and welfare issue: 42 CFR §441.302 in no way states that all services must be provided in unlimited quantities so that the recipient's health and welfare is not comprised. It would certainly be nice if unlimited services could be provided to the Petitioner and I certainly see that reducing certain services may endanger her health and welfare if no one else provides those services. However, 42 CFR §430.25(b) directs SCDHHS to operate its MR/RD Medicaid Waiver in an efficient and cost-effective manner, and to offer unlimited services certainly is not efficient and cost-effective. The renewed MR/RD Medicaid Waiver which became effective January 1, 2010 by CMS approval makes it clear that 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; therefore, if the necessary services cannot be found through these other sources outside of the Waiver, the recipient is free to enter an institution as she has already been found to require institutional care by virtue of her acceptance into the MR/RD Medicaid Waiver. Second, the purpose of the MR/RD Medicaid Waiver is to allow the recipient to live in the community and to avoid institutionalization; however, this goal must be balanced against the goal of operating the Waiver in an efficient and cost-effective manner for an entire population of MR/RD Waiver recipients. The strict purpose of a Waiver as stated in 42 CFR §441.300 is not to specifically keep recipients out of institutions but to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients. SCDHHS has found that services must be reduced in order to operate the Waiver efficiently and cost-effectively; therefore, the Petitioner's reduction of services do not violate the Medicaid Act nor the scope and purpose of the SCDHHS MR/RD Medicaid Waiver.

(G) Petitioner's counsel asserts the Petitioner was adversely affected by the Respondent's elimination of speech and language services, speech therapy, physical therapy, and occupational therapy from the MR/RD Medicaid Waiver and that the Petitioner did not receive notice of the termination of these services; however, Petitioner's counsel has not stated that the Petitioner was receiving any of these services prior to their elimination from the MR/RD Medicaid Waiver nor has she challenged the Respondent's assertion that the Petitioner was not receiving these services. This argument is without merit as the Petitioner was not aggrieved by the elimination of these services from the Waiver.

(H) Petitioner's counsel asserts the Respondent's reduction of MR/RD Medicaid Waiver services was arbitrary and not based on medical necessity or any determination by the Petitioner's treating physician, which violates the Medicaid Act, ADA, and Section 504 of the Rehabilitation Act. As stated earlier the Respondent's reduction of MR/RD Medicaid Waiver services was not arbitrary but based on the need to run the MR/RD Medicaid Waiver efficiently and cost-effectively pursuant to 42 CFR §430.25(b); therefore, medical necessity never had to be considered, this was simply an

unfortunate occurrence secondary to severe State budget reductions. For a discussion of Petitioner's counsel's other assertions, see (C), (D), (E), and (F).

(I) Petitioner's counsel asserts the reduction of Waiver services was not based on reasonable standards and is not in the best interest of the MR/RD Medicaid Waiver recipients, as required by the Medicaid Act. As stated earlier, the Respondent's reduction was based on reasonable standards as proscribed in the Medicaid Act. It is a given that any reduction of services to Medicaid recipients for which they were previously eligible, is most likely not going to benefit the recipient; however, that is not relevant to SCDHHS' need to provide medical services in the most efficient and cost-effective manner to an extremely large number of recipients. Therefore, this assertion is without merit.

(J) Petitioner's counsel asserts the Respondent and its agent, SCDDSN have failed to inform the Petitioner of all feasible alternatives under the MR/RD Medicaid Waiver which would allow her to remain in the least restrictive setting; however, there has been no offer of proof for this assertion and no allegation that SCDDSN has refused to discuss other possible services for which the Petitioner is eligible. As stated in (B) above, the Petitioner and/or her representative certainly have some responsibility to inform the Respondent's agent, SCDDSN if more services are needed.

(K) Petitioner's counsel asserts the Respondent's reduction of Petitioner's PC-2 services violates several sections of the South Carolina Code of Laws. As the Petitioner's counsel points out, the Supremacy Clause of the United States Constitution directs that Federal Law will preempt State Law. As previously written, I find that SCDHHS' reduction of PC-2 services to the Petitioner under the MR/RD Medicaid Waiver is allowed under the Medicaid Act; moreover, I also find that South Carolina Code of Laws §44-6-70(b) and §44-6-40 have not been violated as the Respondent is attempting to provide the most appropriate care, tailored to the Petitioner's needs and delivered in the most cost-effective manner, while operating during severe budget reductions. With regard to South Carolina Code of Laws §44-6-80, Petitioner's counsel has submitted no proof that the Respondent has not submitted to the Governor, the State Budget and Control Board, and the General Assembly an annual report concerning the work of the department including details on improvements in the cost effectiveness achieved and recommended changes for further improvements. This section of State Code of Laws does not require that SCDHHS inform the South Carolina General Assembly prior to making substantial changes in the MR/RD Medicaid Waiver program as Petitioner's counsel asserts.

(L) Petitioner's counsel asserts SCDHHS and SCDDSN have violated the ARRA, South Carolina Code of Laws §44-6-70(f), and South Carolina Code of Laws §44-6-132 by failing to use Federal funds appropriately for the administration of the South Carolina Medicaid program. Regardless of how SCDHHS and SCDDSN used appropriated Federal funds, I do not have the authority to remedy that situation. Respondent's counsel asserts that Petitioner's counsel raised these allegations in a Petition for the South Carolina Supreme Court to take original jurisdiction and grant an

injunction against SCDHHS' imposition of the renewed MR/RD Medicaid Waiver limitations; however, the Supreme Court denied the Petition and declined to grant the injunction. Respondent's counsel asserts that Petitioner's counsel has recently filed a similar action for similar relief in the Federal District Court of South Carolina and Respondent's counsel avows that as a matter of comity I should defer to the District Court for resolution of these issues. I find that 42 CFR §431.220 does not give me the authority to hear such broad issues as whether SCDHHS appropriately used Federal funds in the administration of the Medicaid program and; therefore, these allegations must be heard in the appropriate State Court venue.

DECISION

The Respondent's Motion to File Late Return of Comments on Petitioner's Interlocutory Order Response is **GRANTED.** The Petitioner's appeal of the Respondent's reduction of PC-2 services under the MR/RD Medicaid Waiver due to changes in the MR/RD Medicaid Waiver is hereby **DISMISSED.** While I sympathize and understand the Petitioner's circumstances, I cannot change State Medicaid or Federal policy.

AND IT IS SO ORDERED.

Robert French
Hearing Officer

Dated at Columbia,
South Carolina

May 17, 2010

Exhibit 8

Affidavit of Dr. Melmoth S. Patterson
dated April 16, 2010

STATE OF SOUTH CAROLINA)
)
) Affidavit of Melmoth S. Patterson, M.D.
)
COUNTY OF LAURENS)

1. I have been the primary treating physician for Michelle Morgan for more than twenty years.

2. Michelle has severe mental retardation, autism, cerebral palsy, a seizure disorder, GERD and marked dysphagia. She has a major brain deformity. (8-24-09).

3. Michelle is totally unable to communicate through normal speech and she requires tube feeding due to a progressive deterioration in her ability to eat. (3-23-10). Her feeding tube must be replaced every three months.

4. Michelle takes twelve medications due to her complex medical condition and she is unable to administer or monitor her medications

5. Michelle has a history of "night terrors" and she sometimes stays awake all night, making it difficult for her parents to sleep.

6. Michelle has self-destructive behaviors and she may have a bi-polar disorder, but it is difficult to diagnose her mental condition because of her inability to communicate. (12-1-08 and 8-24-07). Psychological tests have shown that Michelle has profound mental retardation.

7. Michelle has a history of choking (6-26-07) and depression (4-27-04).

8. Michelle's parents both have medical conditions which have required hospitalizations and limit their ability to provide care for Michelle on a 24/7 basis.

9. Michelle's parents have been able to keep her at home because of the services which have been provided by the South Carolina Department of Disabilities and Special Needs.

10. If these services were reduced, Michelle would be likely to have to return to an institution.

11. Michelle has benefitted from services she has received at home and it is likely that her condition would deteriorate if she were forced to return to an institution.

12. Michelle is totally unable to defend herself or to communicate her needs verbally. She would be subject to infections which could jeopardize her general health if she were living in a congregate setting.

13. It is in Michelle's best interest to receive services that she needs to remain in the home without reduction in the services she has been receiving.

Further affiant sayeth not.

Executed this 16th day of April, 2010.

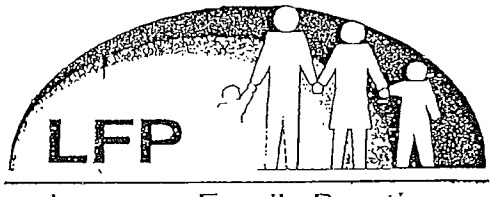
Melmoth S. Patterson, M.D.

SWORN TO BEFORE ME
THIS 16th DAY OF APRIL, 2010.

Notary Public for South Carolina
My Commission Expires: August 7, 2010

Exhibit 9

Letter of Dr. Melmoth S. Patterson
dated April 13, 2010



Laurens Family Practice
106 Parkview Drive • Laurens, South Carolina 29360
Telephone (864) 984-0571 • Fax (864) 984-3610
9100 Hwy 14 • Gray Court, South Carolina 29645
Telephone (864) 876-4888 • Fax (864) 876-4900

To Whom It May Concern:

Re : Miss Michelle Morgan,

Michelle is a patient for whom I have cared for over 35 years. She has severe Cerebral Palsy, difficult seizures, is fed via a peg tube and has major emotional and behavorial problems, all of which have been cared for well by her parents Barbara and Robert, with assist of Personal care aids. It has been brought to my attention that the personal care is being markedly decreased and it should be known that this is not in the patients best interest and will greatly increase her risk or needing hospitalization or instutionalization. She MUST have assistive personal care daily, and this has enabled her to have improved quality of life and to stay home with her parents who provide 24/7 care. Please assist in anyway in restoring full personal care services via DSS. This young lady, by staying at home, and avoiding instutionalization has saved the State of SC hundreds of thousands of dollars over the last 30 years, and she certainly does't need to be abandoned now. Please assist,

Sincerely

Mell S Patterson, MD, CMD
Laurens Family Practice
864-984-0571

4/5/10

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF SOUTH CAROLINA

GREENVILLE DIVISION

CIVIL CASE NO. 6-10-CV-767-RBH-BHH

Peter B., Karen W., Jimmy "Chip" E.,

and Michelle M.,

Plaintiffs,

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,

Defendants.

DECLARATION OF LENNIE MULLIS

Now comes Lennie Mullis who swears and affirms:

I am a behavior support specialist and psychological services provider of MR/RD Medicaid waiver services to Peter B. and Michelle M.

I make this declaration based on my personal knowledge of Peter B. and Michelle M. and my experience working with people who have mental retardation for more than 25 years.

Since Peter B.'s companion services were terminated in July 2009, his anxiety level and symptoms of depression have increased significantly.

Peter B. has lost 10 pounds since his companion services were terminated in July 2009.

Peter has been recently exhibiting other signs which appear to me to be symptoms of stress, including inflamation of his skin and loss of hair.

I am concerned that if Peter's regression in his mental state, his social skills and his medical condition continues, he will be unable to continue to work in competitive employment.

Peter takes tremendous pride in his job and his whole sense of self-worth is related to his work. Peter would be devastated if he lost his job at Palmetto Textiles.

Adult companion services are services which are offered through the MR/RD Medicaid waiver.

The 12 hours a week of companion services Peter received, prior to these services being terminated by SCDDSN and SCDHHS in July 2009, were necessary to maintain his mental and physical well being and to prevent the regression which has occurred since the termination of Peter's companion services.

The Workability Center would be an inappropriate and unnecessarily restrictive placement for Peter because of the lack of stimulation he would receive there and the regression that would occur because of the behaviors of the attendees there. Some of the workshop attendees display physical and verbal aggression.

The social skills of most of the workshop attendees is below Peter's and some of the participants at the workshop exhibit inappropriate social contacts which would be very upsetting to Peter. I would expect Peter's social skills to regress tremendously if he attended the workshop.

Peter would feel isolated and inferior if he were to lose his job and to have to attend the workshop.

Behaviors exhibited by workshop attendees which would be upsetting to Peter include stealing food and invading other persons's personal space.

Before companion services were provided, according to his records and his service coordinator, Peter experienced a dangerous loss of weight. Since his companion services were terminated, he has lost weight rapidly again.

Peter's previous good health condition is deteriorating and this rapid change in his condition is dangerous because of his conditions of diabetes and coronary heart disease.

Peter needs to get exercise, which has been ordered by his physician, to prevent complications from his diabetic condition and his coronary heart disease. Without the encouragement of a companion, Peter will not exercise and he will withdraw into his

apartment.

If Peter's mental health continues to decline, he is at risk of losing his job and having to move to a more restrictive residential setting because of the increase in his anxiety level and the symptoms of depression and the withdrawal he has been exhibiting since his companion services were terminated.

I have provided services to Michelle M. for 4 years which have been funded by the MR/RD Medicaid waiver program.

Michelle is totally dependent upon others for all activities of daily living.

Michelle would be totally unable to defend herself if she were in a facility with persons whose behavior is aggressive.

The workshop or any congregate residential placement would be inappropriate for Michelle at this time and she would regress if she were not able to remain in her home.

Based on my knowledge of Michelle's history, I would expect Michelle's condition to rapidly deteriorate if she were returned to an ICF/MR.

Remaining in her home is the safest placement for Michelle and she risks serious health and medical complications if she were required to return to a Regional Center.

Due to Michelle's medical complications, she would require services in a Regional Center if she were unable to remain at home.

If Michelle were to be moved to a Regional Center, she would require one-on-one supervision because of her tube feeding and the fact that she will try to pull out her gastronomy tube or to stand up while the tube is attached.

It is unsafe for Michelle to walk without hands-on assistance because of her unsteady gate.

I have read this Declaration and I swear and affirm under penalty of perjury, to the best of my knowledge and understanding, that its contents are true.

Lennie S. Mullis

I am familiar with the Declarant and I recognize her voice and I do hereby swear and affirm that this Declaration is her statement, as affirmed to me by telephone.

Sworn to me this 28th day of April,

2010 via telephone.

Nancy C. Law

Notary Public for South Carolina

Commission expires 1-05-2014

Exhibit 3

Documents Related to Albert C. Myers

Nancy C. Law

From: "Patricia L Harrison" <plh.cola@worldnet.att.net>
To: <plhcola@bellsouth.net>
Sent: Monday, September 13, 2010 10:35 PM
Subject: Fw: Albert Myers

From: carolyn myers
Sent: Monday, September 13, 2010 10:31 PM
To: patricia *harrison
Subject: FW: Albert Myers

1. My son, Albert Myers is 31 years old and he was born with a condition of arthrogryprosis, which is a rare congenital disorder characterized by multiple joint contractures and muscle weakness.

2. Al is likely to live a normal life expectancy if he is able to remain in the home and receive appropriate medical and physical care.

3. Complications of arthrogyprosis included a cleft lip, severe spinal scoliosis, growth retardation, bilateral dislocation of both hip joints, abdominal hernias, muscular atrophy plus a predisposition to join contractures.

4. Al aspirated at birth and his brain was damaged due to lack of oxygen.

5. Al is nonverbal and he cannot control his arms or legs and he is totally dependent on others to dress, feed and bathe.

6. Because of problems with aspiration of food, Al must be fed through a gastronomy tube.

7. Al needs physical therapy, including deep muscle stimulation and extensive stretching to increase, preserve and to prevent contractures and to relieve and control the pain from contractures.

8. Al needs occupational therapy which involves training in motor skills in order to establish a means for him to control a motorized wheelchair and augmentative communication control devices as well as addressing psychosocial and emotional implications of living with a disability.

9. Al has required multiple orthopaedic surgeries in his early years to correct severely affected joints and limbs and symptoms such as clubfoot and hernia repair.

10. I have been a single parent since my husband died in 2004 and I would not be able to keep Al at home without the personal care attendant hours provided through the MR/RD Medicaid waiver.

11. I have severe arthritis in my spine and other joints and have recently been diagnosed with bleeding ulcers and compromised pulmonary function.

12. The threat of losing Al's services has created tremendous tension, fear, grief, anxiety and anger at the injustice of the possibility of being unable to continue to keep him at home.

13. My physicians believe that this recent stress of Al's care unsupported and the physical meeting of his needs is responsible for the deterioration in my own health condition.

14 For years, DDSN promised parents like me that they would provide supports in the home if we kept our children at home and now they are punishing parents like me who have given up our careers and our lives to keep our children at home and rewarding those parents who institutionalized their children at an early age. The injustice of what has been given by Al's deceased Father and I for 31 years and what we have done to save the taxpayers of SC over the cost of 31 years of institutional care plus the pride we felt in doing what was right for him and our community has been destroyed by seeing those who are long time residents of our states residential facilities receive services which are being denied to Al. It is difficult to sleep at night with the pain of loss that is in my heart.

I have read the 14 statements contained herein and swear and affirm that these statements are true.

Carolyn Myers

Exhibit 4

Documents Related to Susan Edge

)
AFFIDAVIT OF BRONSON EDGE
COUNTY OF HORRY)

1. I am the parent of Susan Edge, who is 25 years old and lives at home with her mother and me.

2. Susan has profound mental retardation, cerebral palsy, lupus, immune deficiency, seizures, severe osteoporisis and hydrocephalia. She is nonverbal, is unable to walk, incontinent of bowel and bladder and is legally blind. Susan's IQ is 14. She is totally dependent upon others for every activity of daily living.

3. Susan requires two and a half cases of Ensure each month to meet her medical needs, but DDSN has limited waiver participants to receiving only two cases a month.

4. On January 5, 2010, we received a notice reducing the number of cases of Ensure Susan can receive under the waiver to two cases a month, but two and a half cases are required under the order of her physician.

5. The notice had been sent to her Medicaid provider and it was dated December 17, 2009, but we were not provided with a copy of the notice when it was sent or a notice of Susan's right to appeal this limit.

6. When we received the notice on January 5, 2010, we called Susan's DDSN service coordinator and asked her to correct the date because more than ten days had elapsed since the notice of reduction was signed.

7. Susan's service coordinator refused to change the date to the date it was actually mailed to us.

8. This decision reduces Susan's nutritional supplements by 20%, leaving her without the supplements six days a month.

9. There are only a few foods Susan can eat: grits, eggs, chicken and noodles. These foods have to be pureed and they do not meet all of her nutritional needs.

10. Susan needs these nutritional supplements to avoid having to have a feeding tube inserted.

11. If Susan's condition deteriorates to the point that she has to have a g tube inserted to receive tube feeding, Medicaid would pay for all supplements.

12. Susan was not thriving before we began giving her these supplements and her physician has ordered two and one-half cases of Ensure a month.

13. Susan is at risk of institutionalization because of this reduction and because we cannot find providers in our area who can meet her complex medical needs.

14. DDSN has told us that we cannot leave the house when respite services are provided because they will not allow the respite caregiver to administer medications.

15. DDSN requires respite caregivers to undergo training without pay for the time they spend and they require the caregiver to pay for background checks.

16. Once fica taxes are taken out of the amount DDSN pays caregivers for respite services, they receive less than minimum wage.

17. DDSN will pay $270 per day for Susan to receive respite services in an institution operated by DDSN.

18. DDSN treats respite caregivers as employees of the family for fica, workman's comp and unemployment purposes, although they have to udergo training and meet requirements established by DDSN.

19. Susan is at imminent risk of institutionalization due to our health and the inability to access home-based services which are needed to keep her safely at home.

20. We want to keep Susan at home, but DDSN will not provide her with the services and nutritional supplements they would provide if she were in an ICF/MR institution.

Further deponent sayeth not.

Bronson Edge

Bronson Edge

SWORN TO BEFORE ME THIS 7th day of January 2010.

Barbara Anderson

My Commission expires

9-3-19

AFFIDAVIT OF SANDRA EDGE

COUNTY OF HORRY

1. I am the parent of Susan Edge, who is 25 years old and lives at home with her father and me.

2. Susan has profound mental retardation, cerebral palsy, lupus, immune deficiency, seizures, severe osteoporisis and hydrocephalia. She is nonverbal, is unable to walk, incontinent of bowel and bladder and is legally blind. Susan's IQ is 14. She is totally dependent upon others for every activity of daily living.

3. Susan requires two and a half cases of Ensure each month to meet her medical needs, but DDSN has limited waiver participants to receiving only two cases a month.

4. On January 5, 2010, we received a notice reducing the number of cases of Ensure Susan can receive under the waiver to two cases a month, but two and a half cases are required under the order of her physician.

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10. Susan needs these nutritional supplements to avoid having to have a feeding tube inserted.

11. If Susan's condition deteriorates to the point that she has to have a g tube inserted to receive tube feeding, Medicaid would pay for all supplements.

12. Susan was not thriving before we began giving her these supplements and her physician has ordered two and one-half cases of Ensure a month.

13. Susan is at risk of institutionalization because of this reduction and because we cannot find providers in our area who can meet her complex medical needs.

14. DDSN has told us that we cannot leave the house when respite services are provided because they will not allow the respite caregiver to administer medications.

15. DDSN requires respite caregivers to undergo training without pay for the time they spend and they require the caregiver to pay for background checks.

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18. DDSN treats respite caregivers as employees of the family for fica, workman's comp and unemployment purposes, although they have to udergo training and meet requirements established by DDSN.

19. Susan is at imminent risk of institutionalization due to our health and the inability to access home-based services which are needed to keep her safely at home.

20. We want to keep Susan at home, but DDSN will not provide her with the services and nutritional supplements they would provide if she were in an ICF/MR institution.

Further deponent sayeth not.

Sandra Edge
Sandra Edge

SWORN TO BEFORE ME THIS 7th day of January 2010.

Barbara Anderson
My Comm Expires 9-3-19

WATERWAY FAMILY MEDICINE, P. A.

Eston E Williams, MD
Stephen D Grubb, MD

3600 Sea Mountain Hwy, Suite C
Little River, SC 29566
(843) 399-4848

Tom A Christensen, MD
Patrick K Ryan, DO

January 7, 2010

RE: Susan Edge
DOB: 07-10-84

To Whom It May Concern:

For 25 years I have been her treating physician for Susan Edge who has cerebral palsy, seizure disorder, osteopenia, immunodeficiency.

Susan requires two and one-half cases of Ensure to meet her nutritional needs and to maintain her weight. If her nutritioinal supplements are reduced to two cases a month, six days a month, she will not be able to maintain in the home.

Susan has a relative, Lynn Edge, who is familiar with her care and is capable of administering her medications if given instructions by Susan's parents. With proper training by Susan's parents, Susan coud be left in the care of Lynn Edge so that Susan's parents can receive respite from their care giving duties.

Without this respite, the health of Susan's parents is likely to decline and this will increase the likelihood that she will be placed in an institution. Susan's medical status would be likely to decline significantly if she were placed in an institution. If you have any questions please do not hesitate to call my office at the number listed above.

Sincerely,

Stephen D. Grubb, M.D.

SDG/ae

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

NOTICE OF REDUCTION OF SERVICE

To: Reliable Medical

Address: 1639 Hwy 544
Conway, SC 29526

Participant's Name: Susan Edge DOB: 7/10/84 Medicaid #: 1216779801

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 12/31/2009 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
- ☒ 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: Service is now being capped under the MR/RD Waiver.
- ☐ Medical condition has improved
- ☐ Participant/legal guardian requested

Comments (required): Changes to the MR/RD Waiver effective 1/1/10, any service over the capped amount must be reduced. (Ensure being reduced to 2 cases/month)

Service Coordination Provider: HCDSN Service Coordinator Name: Allison McKay

Address: 250 Victory Lane
Conway, SC 29526

Phone # (843) 347-3010

A McKay
Signature of Service Coordinator

12/17/09
Date

Original: Provider / Copy: Participant/legal guardian, File

APPEALS PROCESS MUST BE ATTACHED

REQUEST FOR RECONSIDERATION

Name- Susan Edge
Address 1290 Hwy 66
Conway, SC 29526

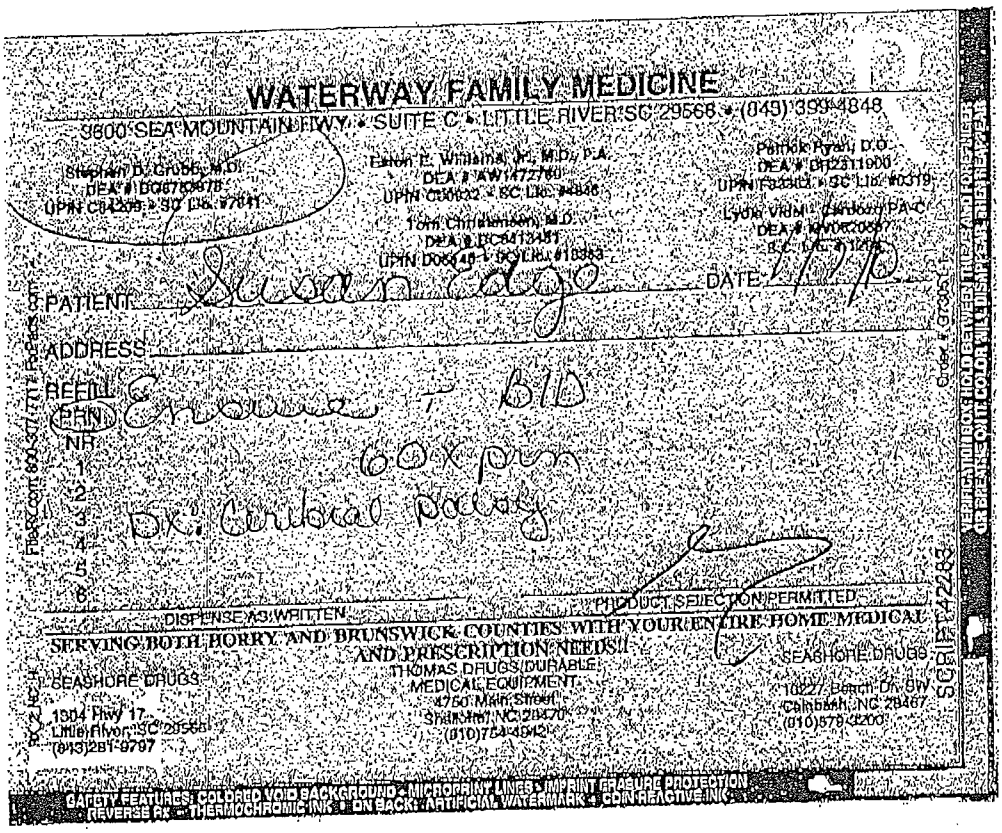
Dr. Buscemi, 1-6-10

I am requesting a reconsideration of a Medicaid Waiver Service that my daughter receives monthly. I was informed in writing on Jan 5, 2010 by letter dated Dec 17, 2009 (attached) that she would be receiving 2 cases of Ensure. She has been receiving 2 ½ cases per month. Susan has many, many needs, including nutritional.
About 20 years ago, she was very sick, and was not growing. She only weighed 40 pounds. There were many hospital stays and tests were completed. One of the findings was Erosive Esophagitis with much bleeding. There are many foods and medicines she can not tolerate. Her daily, everyday, diet she can eat consists of four foods. These are grits, eggs, chicken, and egg noodles, 2 cans of Ensure and water. She now weighs 135 lbs at age 25. As long as she is thriving, she does not need a feeding tube.
Susan's Ensure has been reduced to 2 cases per month (48 cans). This is only enough to last 24 days each month. She receives 2 cans Ensure daily prescribed by her physician. This leaves 6 days without Ensure.
If Susan's diet is limited MORE, her health will regress. Her care at home will become more difficult for her father and me if she has a feeding tube. She already has a port-a-catheter for I.V. antibiotics at home, and a pubic catheter (urinary).
If her nutritional needs are not met and her health deteriorates we will have to strongly consider institutional care.
I am asking for the 12 cans Ensure to be restored each month. Ensure is not a snack for her. This nutrition has helped save her life.

Person Requesting Reconsideration on behalf of Appellant.

Sandra Edge

Sandra Edge
(Mother)



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Baron E. Williams, Jr., M.D., P.A.
DEA # AW1472760
UPIN C30622 • SC Lic. #4848

Tom Christianson, M.D.
DEA # BC6413481
UPIN D06441 • SC Lic. #18383

Patrick Ryan, D.O.
DEA # BR2311900
UPIN F33101 • SC Lic. #0319

Lydia Vann Gardner, PA-C
DEA # MG0620597
S.C. Lic. #12478

PATIENT: Lauren Edge DATE: 1/12/12

ADDRESS:

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60 x pcs
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THE STATE OF SOUTH CAROLINA
IN THE ADMINISTRATIVE LAW COURT

Appeal from the Division of Hearings and Appeals
South Carolina Department of Health and Human Services

Janet R. Goode, Hearing Officer

Docket Number: 10-ALJ-08-0504-AP

Albert Cooper Myers,

Appellant,

vs.

South Carolina Department of Health
and Human Services,

Respondent.

RESPONDENT'S RETURN TO MOTION FOR EXTENSION OF TIME AND CONSOLIDATION AND CROSS-MOTION TO DISMISS

Richard G. Hepfer
Deputy General Counsel
Office of General Counsel
SC Department of Health and
Human Services
PO Box 8206
Columbia, South Carolina 29202
(803) 898-2791 voice
(803) 255-8210 fax
hepfer@scdhhs.gov
Attorney for Respondent

TO: The Honorable Shirley C. Robinson, Administrative Law Judge, South Carolina Administrative Law Court, 1205 Pendleton Street, Suite 224, Columbia, SC 29201-3755 AND Ms. Patricia Harrison, Law Office of Patricia L. Harrison, 611 Holly Street, Columbia, SC 29205

RESPONDENT'S RETURN TO MOTION FOR EXTENSION OF TIME AND CONSOLIDATION

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 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. 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, Respondent) is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the Waiver. This appeal was directly from a DDSN Reconsideration of a reduction in the number of cases of liquid nutrition provided to the Appellant. The reduction was the result of the limitations set forth in the renewed Waiver. The Reconsideration upheld the original reduction, thus, this appeal was before the Appeals Division of the DHHS.

Prior to January 1, 2010, the Appellant was receiving forty-five (45) hours of Personal Care Aide II (PCAII) Services per week, over 500 annual hours of Respite Care Services, and four (4) unit of Physical Therapy per week, as approved prior to the Waiver Renewal. A comparison of Appellant's complete services package is at page 42 of the Record. Because of the new limits,

PCAII Services was reduced to twenty-eight (28) hours per week. Respite Care Services were increased to 101 hours per month. Physical Therapy was eliminated.

Procedural Posture

1. In late December, 2009, or early January, 2010, the Appellant's mother apparently sought a reconsideration of the reduction in the amount of liquid nutrition available to the Appellant.
2. On January 13, 2010, Dr. Beverly A.H. Buscemi, the Director of DDSN sent a letter to the Appellants upholding the decision to reduce Personal Care Aide II (PCAII) Services, Respite Care Services, and eliminate Physical Therapy Services. See page 49 of the Record.
3. On February 11, 2010, that reconsideration determination was appealed to the Division of Appeals and Hearings of the SCDHHS. See page 48 of the Record.
4. On February 25, 2010, the Assigned Hearing Officer, Janet R. Goode, issued Interlocutory Orders (Cause of Action) indicating that she was not inclined to set aside the new Waiver provisions, but invited the Appellant to specify errors. See page 40 of the Record.
5. On or about March 15, 2010, the Appellant through her attorney specified numerous errors of law. See page 34 of the Record.
6. On March 30, 2010, the Respondent through its attorney responded to the errors of law specified by the Appellant. See page 12 of the Record.
7. On May 6, 2010, the Department's Hearing Officer issued an Order of Dismissal which essentially said that the Appellant had not stated a cause of action for which the Hearing Officer could grant relief. See page 2 of the Record.
8. The Order of Dismissal was received by the Appellant's attorney on May 10, 2010. See page 58 of the Record.
9. On May 21, 2010, the Appellant filed a Request for Reconsideration of the Hearing Officer's Decision. Not included in the Record.

10. On June 18, 2010, the Appellant filed a Notice of Appeal to the Administrative Law Court.
11. On August 12, 2010, the DHHS Division of Appeals and Hearings transmitted the Hearing Record to the court. See cover letter of Robert French, dated August 12, 2010.
12. On September 13, 2010, the Appellant filed the current Motion.

Issues presented in the Appellant's Motion for Extension of Time and Consolidation

1. Because of the absence of the Requests for Reconsiderations in the Hearing Record, should an extension of time be given for the Appellant to file her Brief?
2. Because the cases share similar questions of law and involve Waiver participants, should this case be consolidated with three (3) other cases (10-ALJ-08-0501, 0502 & 0503) also involving reductions in services to individuals participating in the MR/RD Waiver?

Arguments

1. The Department has no particular objection to the Appellant's being granted an extension of time in which to file her Brief, but it should not be predicated on the absence of the requests for reconsideration in the Hearing Record.

Under the Department's Appeals and Hearing regulations there exists no mechanism for requesting a reconsideration of the Department's Final Administrative Decisions. See S.C. Code R. 126-150 et seq. A previous provision in the Department's regulations, former S.C. Code Ann. R. 126-152(D) did allow for a reconsideration request to the Department's Director, but that provision was deleted in 1997. See State Register, Volume 21, Issue 3, March 28, 1997.

Thus, the Hearing Officer had no jurisdiction to entertain a Motion to Reconsider and the Order of Dismissal received by the Appellant's attorney on May 10, 2010 was the final agency action on the matter.

Therefore, the request for reconsideration is not appropriately a part of the Hearing Record and is not necessary for a resolution of the issues.

2. Because the reduction in services in this case is different from the reduction in services in the three (3) other cases, the Respondent believes that this case should not be consolidated with the other cases. However, the Respondent does not object to consolidation of the sole issue of whether the four (4) cases were properly decided on the legal arguments.

Clearly the Hearing Officer saw the Appellant's arguments in this case as a legal attack on the Department's ability to amend the Waiver in order to limit services, and not a complaint against the application of the new policy to the Appellant. Indeed, the vast majority of the Appellant's claims, as set forth in the Appellant's Reply (page 34 of the Hearing Record) to the Interlocutory Order (page 40 of the Record) are couched in terms of the Respondents' actions in limiting the services in the Waiver being a violation of the law. The Appellant argued that:

a) The Medicaid regulations did not allow dismissal of the matter without a hearing;
b) The reductions in services are violative, per se, of Olmstead v. L. C. ex rel Zimring, 527 U.S. 581 (1999);
c) The reductions in services are violative, per se, of the American Recovery and Reinvestment Act;
d) The Governor and the State Directors of the Programs misused State funds invalidating the new Waiver;
e) There was inadequate notice of the changes, thereby invalidating the new Waiver; and
f) That the agencies, in establishing the new Waiver, violated their enabling legislation.

In her Interlocutory Order, the Hearing Officer essentially asked for a more definite statement of the issues. She was asking for help in framing the issues and received statements about how the new Waiver violated the law. In her Order of Dismissal, the Hearing Officer examined all of those arguments as arguments to invalidate, per se, the new Waiver, not as problems in the application of the new Waiver restrictions to the Appellant. The Hearing Officer found the arguments inadequate reasons to invalidate the new Waiver. If the new Waiver was valid, then it is obvious that the new limitations were required by the terms of the Waiver and properly applied to the Appellant. The limitation at issue was a straightforward numerical reduction in the number of hours of PCAII Services, and an elimination of Physical Therapy Services. It was

clear to the Hearing Officer how the new Waiver limitations adversely affected the Appellant – specific reduction and elimination of services.

No other limitations or reductions were raised in the Request for Reconsideration response that was issued by the Director of DDSN on January 13, 2010. In his appeal request, the Appellant did raise elimination of Occupational and Speech Therapy and denial of coverage for Augmented Communications evaluation and equipment, but there is no evidence that these services were eliminated from the Appellant's service package. Thus, the effects of the new Waiver limitations upon the Appellant's living situation were apparent to the Hearing Officer.

Obviously, the legal arguments are preserved for review. Those legal arguments were raised in all of the cases, and they could, logically, be reviewed simultaneously to again determine if the Hearing Officer was correct in deciding that the new Waiver did not, per se, violate the law.

However, if it is determined that the Hearing Officer was in error in deciding the matter on the legal arguments alone, then the cases must not be consolidated because the individual situations and the limitations applied are different for each of the Appellants.

Conclusion

As to the extension of time, the Motion should be granted on the basis of the Appellant's attorney's request, but not on the basis of the lack of documentation in the Hearing Record. As to the Consolidation, the Motion should be granted for the purpose of determining whether the Hearing Officer could decide the matter on the law alone. If not, the cases must remain as individual cases, because the limitations applied and the living situations of the Appellants are different.

CROSS-MOTION FOR DISMISSAL

There is no provision in the Department's hearing regulations for a request for reconsideration. As mentioned above, the previous provision for reconsideration was repealed in 1997. Since there is no longer a provision in the Department's regulations for reconsideration, in this case the Order of Dismissal constituted the final agency action. Administrative Law Court Rule 33 requires that a "...notice of appeal should be filed within thirty (30) days of receipt of the decision from which the appeal is taken."

In this case, the Order of Dismissal was received by the Appellant on May 10, 2010, and the appeal was taken on June 18, 2010, well past the required time. See J. L. D. v. SCDHHS, 01-ALJ-08-0251-AP.

Therefore, the matter must be dismissed as untimely filed.

Respectfully Submitted,

Richard G. Hepfer
Deputy General Counsel
Office of General Counsel
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Voice: (803) 898-2791
Fax (803) 255-8210
hepfer@scdhhs.gov
Attorney for the Respondent

Columbia, South Carolina
September 24, 2010

THE STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Susan Edge, 10-MISC-052, formerly No.10-ALJ-08-0501-AP
Jimmy W. Eubanks, Jr., 10-MISC-017, formerly No.10-ALJ-08-0502-AP
Michelle Morgan, 10-MISC-053, formerly No.10-ALJ-08-0503-AP
Albert Cooper Myers, 10-MISC-040, formerly No.10-ALJ-08-0504-AP

Docket No.10-ALJ-08-0501-AP

Susan Edge, Jimmy W. Eubanks, Jr., Michelle Morgan, and
Albert Cooper Myers, Appellants,

v.

South Carolina Department of Health and Human Services, Respondent.

APPELLANTS' MOTION TO ALTER OR AMEND

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

ATTORNEY FOR APPELLANTS

FILED
NOV 21 2011
SC ADMIN. LAW COURT

I. Introduction

The Administrative Law Court correctly adopted the holding of this Court in *Hickey v. DHHS,* in this consolidated case, finding that the actions taken by Respondent in terminating and reducing services do not have the force and effect of law because they were never promulgated as regulations. 10-ALJ-08-0656-AP.

Having determined that the reductions resulting from the January 1, 2010 amendments to the MR/RD Medicaid waiver were not valid, Appellants respectfully request that this Court consider altering or amending its factual findings and its holdings related to the constitutional due process issues raised by Appellants. Since the reductions in services were void *ab initio* because they were not promulgated as regulations, it is not necessary for this Court to address the constitutional due process issues related to defective notice and ex parte communications with the tribunal. In the alternative, Appellants respectfully request that the Court reconsider its ruling and amend the order as set forth below.

II. The United States District Court issued an order granting a preliminary injunction prohibiting Respondent from reducing services of Appellants Eubanks and Morgan on March 7, 2011.

The Administrative Law Court erred in finding that the United States District Court has not ruled on the Appellant's motion for a preliminary injunction. Order at page 6. The district court granted the motion for preliminary injunction filed by Eubanks and Morgan on March 7, 2011. This order, which is attached as Exhibit 1, was referenced in Appellant's Reply Brief on pages 1 and 2.

III. **Whether the reductions were imposed as a consequence of substantial reductions in State budget appropriations or in order to maintain the monopoly of DDSNproviders is a matter of fact which could not be determined without an evidentiary hearing.**

The order states in the section titled "Factual Background" that the changes "were imposed as a consequence of substantial reductions in State budget appropriations for the agency." However, Appellants have alleged that the amendment was adopted not because of budget reductions, but for the purpose of maintaining the monopoly of DSN Boards and to purchase real estate. Appellant's Brief at 7 and facts alleged in *Karen W. v. Sanford* in the Appendix at 1. Whether the reason for the reductions given by the Respondent is true or a pretext could not be determined without an evidentiary hearing, which is not necessary given the Court's adoption of *Hickey*. The Court may take judicial notice of the Report of the State Comptroller General indicating that DHHS allowed more than $225 million to "lapse" during the year the waiver was amended. Exhibit 2 at page 4. Appellants respectfully request that the order be amended to state that "*Respondents claimed that* the changes concerning the MR/RD waiver program were imposed as a consequence of substantial reductions in State budget appropriations for the agency."

IV. **Appellants did not abandon their claim that Respondent violated 42 C.F.R. 431.210.**

Appellants respectfully request that the Court review the briefs and reconsider its ruling on the defective notice issue. The issue of the violation the notice requirements of 42 C.F.R. 431.210 was specifically included in Appellant's statement of the second issue on appeal, which states:

> Has Respondent violated 42 U.S.C. 1396a(a)(3), the *requirements of 42 C.F.R. 431.210* and the Appellant's Constitutional due process rights by failing to provide an evidentiary

hearing and a final decision within ninety days of Appellant's request for a fair hearing?

(Emphasis added.) Appellant's Brief at 26. The argument section of Appellants' Brief states:

> States that accept Medicaid funds obligate themselves to comply with all federal Medicaid laws. *Doe v. Kidd, Supra*. CMS, the federal Medicaid agency, has promulgated regulations to implement the statutes at 42 C.F.R. 431.200 et seq. which Respondent is bound to follow.

Id. at 26. The Respondent clearly understood that Appellants were appealing the defective notice issue. Indeed, Respondent included in its brief the specific section of the law upon which Appellant based the defective notice issue and a discussion of why it claimed the requirement was not followed. The following language is contained in Respondent's Brief at page 8:

> The Appellant has asserted that the SCDDSN's initial notice, if indeed provided to the Appellant, about the reduction in services was defective because it did not comply with the following regulation:
>
> > § 431.210. Content of notice.
> > A notice required under Sec. 431.206(c)(2), 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.

Respondent's Brief at 9. Ignoring the clear requirements of this federal regulation, Respondent argued that it did not matter that it failed to include a reference to the specific regulations upon which they rely because "the Appellant knew exactly what was being reduced and eliminated and

what to appeal." Id.

This is a matter of extreme public importance, because Medicaid waiver participants are placed at a disadvantage when they are required to prepare for a fair hearing without being informed of the regulations or laws upon which DHHS has relied. This violation of subject to repetition, yet it has evaded review.

As Appellants argued in the Reply Brief:

> 42 C.F.R. § 431.210 means something. CMS did not promulgate this regulation as an optional or suggested procedure. ...Likewise, CMS established a clear requirement that notices of reductions or terminations of services must contain "The specific regulations that support, or the change in Federal or State law that requires the action. Nowhere in any notice provided by DHHS was the regulation the agency relied upon specified.

Appellants respectfully request that the Court reconsider the defective notice issue and that it issue an order either (1) finding that the issue of defective notice was preserved but a ruling on that issue it is not necessary to rule upon this issue because the reductions were *invalid ab initio*, or (2) finding that the notices provided to Appellants failed to comply with the clear requirements of 42 C.F.R. § 431.210(c) because they failed to include the specific regulation or law that requires the action.

V. The ex parte communications between DDSN employees and the Office of Hearings and Appeals violated Appellant's due process rights.

Appellants respectfully request that the Court review and reconsider its decision finding that ex parte communications between the DHHS Office of Appeals and Hearings and the agency and parents of Edge are not improper. Medicaid participants are already at a disadvantage in these proceedings. By definition, Medicaid recipients are impoverished. In this case, three of the individuals have intellectual disabilities which prohibit them from defending themselves against

improper government action. Giving the agencies the right to secretly influence the Office on Appeals and Hearings puts Medicaid recipients at an extreme disadvantage and it violates Judicial Canon 3. Because the agency refused to provide an evidentiary hearing, Appellant did not have an opportunity to inquire about how the director of the Office on Appeals and Hearings used the ex parte information and whether it was shared with the hearing officer who rendered the decision.

The United States Court of Appeals for the Fourth Circuit addressed the unfairness of ex parte communications in *RZS Holdings AVV v. PDVSA Petroleo S.A.*, 506 F.3d 350 (4th Cir. 2007). In that case, the court recognized that " 'as a general rule, ex parte communications by an adversary party to a decision-maker in an adjudicatory proceeding are prohibited as fundamentally at variance with our conceptions of due process.' " *Thompson v. Greene,* 427 F.3d 263, 269 n.7 (4th Cir. 2005) (quoting *Doe v. Hampton,* 566 F.2d 265, 276 (D.C. Cir. 1977)). They "should be avoided whenever possible."*United States v. Napue*, 834 F.2d 1311, 1318 (7th Cir. 1987) (concluding that ex parte communications "should be avoided whenever possible"). Only when there is a compelling justification, such as the need to act quickly or to keep sensitive information confidential, should there be justification for ex parte communications with the tribunal. *United States v. Thompson*, 827 F.2d 1254, 1258-59 (9th Cir. 1987) (concluding that departures from general rule disfavoring ex parte communications must have compelling justification such as need to act quickly or keep sensitive information from opposing party). Ex parte communications conflict with the "fundamental precept of our system of justice - that fair hearing requires "reasonable opportunity to know the claims of the opposing party and to meet them"). ; *In re Paradyne Corp.,* 803 F.2d 604, 612 (11th Cir. 1986) (explaining that ex parte

hearings are disfavored because they conflict with fundamental precept of our system of justice - that fair hearing requires "reasonable opportunity to know the claims of the opposing party and to meet them").

A guiding principal of the Code of Judicial Conduct requires judges to avoid the "appearance of impropriety" so as "to protect the integrity of the judiciary through safeguarding its impartiality and the public's faith in that impartiality." Jud 4-1999. In that opinion, the committee warned that even when attending a Christmas party hosted by a litigant "the Judge must still abide by other specific requirements, for example, not to engage in ex parte contact concerning a matter before that Judge. See S.C.A.C.R. 501, Canon 3B(7)." Id.

Canon 3 of the Code of Judicial Conduct provides that:

> A judge should accord to every person who is legally interested in a proceeding, or his lawyer, full right to be heard according to law, and, except as authorized by law, neither initiate nor consider ex parte or other communications concerning pending or impending proceeding.

Rule 501, Canon 3(A)(4). It is clear from the facts of this case that such communication was initiated either by the Office of Hearings and Appeals or a DDSN employee.

Judicial Ethics Opinion 5-94 held that a judge may not communicate with a party, even after a decision has been ordered from the bench, when the opposing party defaulted and failed to appear at a hearing.

> Discussing the contents of an order outside of the presence of the opposing party would amount to ex parte communications, even in a default matter. Canon 3 specifically prohibits ex parte communications and states:
>
> > A judge should accord to every person who is equally interested in a proceeding, or his lawyer, full right to be heard according to law, and, except as authorized by law, neither initiate nor consider ex parte or other communications concerning a pending or impending proceeding.

The finding that a DHHS hearing officer may communicate with an employee of DDSN without notice to the Appellant sets a dangerous precedent which should be avoided by this Court. In a case pending before the South Carolina Supreme Court, it is alleged that Robert French, who is also the ex parte communicant in this case, participated in prohibited ex parte contact with third parties which improperly influenced his decision. Oral arguments were held in *Pruitt v. DHHS* on November 3, 2010. This Court may take judicial notice that Issue 2 in that case before the South Carolina Supreme Court addresses the participation of Mr. French in prohibited ex parte communications:

> Issue 2. The hearing officer erred as a matter of law by considering evidence outside of the record in reaching his conclusion that SSA did not award Appellant disability benefits based on a diagnosis of mental retardation.

These violations are subject to repetition, yet they have evaded review. This is especially problematical and prejudicial where the Appellant is not entitled to receive a *de novo* hearing on appeal from the decision of the agency. The hearing officer determines what evidence will be included in the record, what witnesses will be allowed to testify and what standards to apply. If the information presented in the ex parte communication is not worthy of consideration, there is no need to provide it to the Office of Appeals and Hearings. If it is important, the appellant has the right to know that this communication occurred and what was communicated to the tribunal. The risk to the Appellant of not knowing what information has been provided to the tribunal outweighs any governmental interest in allowing such communications.

VI. Conclusion

For the reasons set forth herein, Appellants respectfully request that the Court reconsider its order and amend said order as set forth herein.

Respectfully submitted,

Patricia L. Harrison
611 Holly Street
Columbia, South Carolina
803 256 2017
plh.cola@att.net
Attorney for the Appellants

November 19, 2011
Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Susan Edge, 10-MISC-052, formerly No.10-ALJ-08-0501-AP
Jimmy W. Eubanks, Jr., 10-MISC-017, formerly No.10-ALJ-08-0502-AP
Michelle Morgan, 10-MISC-053, formerly No.10-ALJ-08-0503-AP
Albert Cooper Myers, 10-MISC-040, formerly No.10-ALJ-08-0504-AP

Docket No.10-ALJ-08-0501-AP

Susan Edge, Jimmy W. Eubanks, Jr., Michelle Morgan, and
Albert Cooper Myers, Appellants,

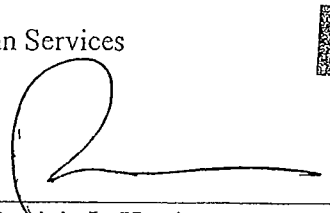
v.

South Carolina Department of Health and Human Services, Respondent.

CERTIFICATE OF FILING AND SERVICE

I, Patricia L. Harrison, Attorney for Appellants, certify that I have this day, November 21, 2011, filed one copy of the foregoing *Motion to Alter or Amend* with the S.C. Administrative Law Court. I further certify that I have also this day served one copy of the foregoing *Motion to Alter or Amend* upon Respondent to their counsel of record with sufficient first-class postage thereon:

Richard G. Hepfer, Esquire
Office of General Counsel
SC Dept of Health and Human Services
PO Box 8206
Columbia, SC 29202



Patricia L. Harrison

FILED
NOV 21 2011
SC ADMIN. LAW COURT

Exhibit 1

Order and Opinion of Judge Michelle Childs dated March 7, 2011,
Peter B., Jimmy "Chip" E., and Michelle M. v. Marshall C. Sanford, et al.
Case No. 6:10-cv–00767

FILED
NOV 21 2011
SC ADMIN. LAW COURT

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

Peter B., Jimmy "Chip" E., and Michelle M.,	
Plaintiffs,	
v.	ORDER AND OPINION
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,	C.A. No.: 6:10-cv-00767-JMC
Defendants.	

Plaintiffs Peter B., Jimmy "Chip" E., and Michelle M. ("Plaintiffs") bring this action against Defendants Marshall C. Sanford, Emma Forkner, Beverly Buscemi, Kelly Floyd, The South Carolina Department of Health and Human Services ("DHHS") and The South Carolina Department of Disabilities and Special Needs, 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 Magistrate Judge's Report and Recommendation [Doc. 71] recommending that Plaintiffs' Motion for Preliminary Injunction [Doc. 12] be granted. After a thorough review of the record in this matter, the applicable law, the Magistrate Judge's Report and Recommendation, and Defendants' objections, the court adopts the Magistrate Judge's Report and Recommendation for the reasons stated below.

STANDARD OF REVIEW

The Magistrate Judge makes only a recommendation to this court. The recommendation has no presumptive weight. The responsibility to make a final determination remains with this court. *See Mathews v. Weber*, 423 U.S. 261, 270-71 (1976). The court is charged with making a *de novo* determination of those portions of the Report and Recommendation to which specific objection is made, and the court may accept, reject, or modify, in whole or in part, the recommendation of the Magistrate Judge or recommit the matter with instructions. 28 U.S.C. § 636(b)(1).

FACTUAL AND PROCEDURAL BACKGROUND

The Report and Recommendation sets forth in detail the relevant facts and procedural background of this matter, and the court incorporates by reference the Magistrate Judge's recitation [Doc. 71, at 2-7].[1]

DISCUSSION

I. Justiciability

Defendants contend that the Magistrate Judge erred in finding this case ripe for adjudication. Specifically, Defendants contend that Chip and Michelle do not present the court with a justiciable controversy because they have not actually been subject to the proposed reduction in services due

---

[1]Defendants note that the Magistrate Judge inaccurately described the concept of "waiver." In describing the operation of the waiver, the Magistrate Judge attributed the decision to exercise a waiver to certain qualifying individuals. By way of clarification, the actual waiver is an act of the Federal DHHS Secretary. Once the waiver is put in place, qualifying individuals may exercise certain service options including the option to participate in the provision of services outside the institutional setting.

Defendants also take issue with the Magistrate Judge's estimation of hours provided to Chip and Michelle for personal care and respite services before and after the service changes at issue in this case. The court understands that the exact computation of relevant service hours is a point of dispute between the parties. However, for purposes of this motion, the exact calculation is unnecessary as there is no dispute that the changes effected by the January 1st Amendment ("Amendment") alters the allocation of the type of services provided prior to the Amendment, even if the total number of service hours provided changes slightly or not at all as Defendants contend.

to Defendants' promise to maintain pre-Amendment service levels during the pendency of the State appeals process.

The federal court has jurisdiction over an action only where a justiciable "case or controversy" exists. To satisfy the requirements of Article III, a plaintiff "must allege some threatened or actual injury ..." *Linda R.S. v. Richard D.*, 410 U.S. 614, 617 (1973). The alleged injury must be sufficiently real and not merely conjectural or hypothetical. *Blum v. Yaretsky*, 457 U.S. 991, 1000 (1982) (quoting *O'Shea v. Littleton*, 414 U.S. 488, 494-96 (1974). The requirement that the harm alleged be of sufficient immediacy does not, however, require plaintiffs "to await the consummation of threatened injury to obtain preventive relief." *Id.* (citations omitted).

In this case, the proposed changes under the Amendment in the case of Chip and Michelle and the actual changes imposed on Peter B. represent a modification of services that could substantially impact each of their abilities to remain in the community. While the court recognizes that Chip and Michelle's services have been temporarily stayed at the discretion of Defendants, their ability to seek redress and more stable resolution through the court remains independent of the vagaries of Defendants. The evidence in the record, as thoroughly recited by the Magistrate Judge, demonstrates that the threat of institutionalization is very real and Plaintiffs' claims are ripe for adjudication now. *See Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1181 (10th Cir. 2003) (findings that an individual need not be institutionalized before he could challenge a discriminatory law or policy under the ADA).

II. Injunctive Relief[2]

Defendants also argue that the Magistrate Judge erroneously recommended that a preliminary injunction issue because there is no likelihood of irreparable injury and it is unlikely that Plaintiffs will prevail on the merits.

"A preliminary injunction is an 'extraordinary remed[y] involving the exercise of very far-reaching power to be granted only sparingly and in limited circumstances.'" *MicroStrategy, Inc. v. Motorola, Inc.*, 245 F.3d 335, 339 (4th Cir. 2001); *see also Real Truth About Obama, Inc. v. Fed. Election Comm'n*, 575 F.3d 342, 345 (4th Cir. 2009), *vacated by* 103 S. Ct. 2371 (April 26, 2010), *reinstated in relevant part by* 607 F.3d 355 (4th Cir. June 8, 2010). Generally, the goal of a preliminary injunction is to "protect the status quo and to prevent irreparable harm during the pendency of a lawsuit, ultimately to preserve the court's ability to render a meaningful judgment on the merits." *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d 517, 525 (4th Cir. 2003).

To determine whether a plaintiff is entitled to a preliminary injunction, the plaintiff must demonstrate "(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." *Winter v. Natural Resources Defense Council, Inc.*, 129 S. Ct. 365, 374 (2008). "[A]ll four requirements must be satisfied." *Real Truth About Obama, Inc.*, 575 F.3d at 346; *see also Winter*, 129 S. Ct. at 376.

First, Defendants contend that it is very unlikely that the reduction in services to Plaintiffs will result in institutionalization; and, therefore, there is no likelihood of irreparable injury. More particularly, Defendants claim that the Magistrate Judge's recommendation was based on

[2]Defendants ask the court to defer to the State court actions in the Administrative Law Court and the appellate court related to Peter. The State court actions do not relate to Plaintiffs' ADA claims. Additionally, the State court dispositions thus far have not evaluated the merits of injunctive relief, but rather relied on State court procedural law.

conclusions of the possible effects of institutionalization instead of the actual possibility that Plaintiffs may be placed in an institution based on the reduction in services.

Plaintiffs seeking injunctive relief must demonstrate that irreparable harm is likely in the absence of an injunction, not merely speculative. *Winter*, 129 S. Ct. at 376. Plaintiffs seeking injunctive relief must do more than establish the "'possibility' of irreparable harm." *Id.* at 375. Instead, the "frequently reiterated standard requires plaintiffs seeking preliminary relief to demonstrate injury is *likely* in the absence of an injunction." *Id.* (emphasis supplied) (citing *Los Angeles v. Lyons*, 461 U.S. 95, 103 (1983)); *see also Real Truth About Obama, Inc.*, 575 F.3d at 346-48 (holding that the preliminary injunction standard articulated in *Winter* has overruled the Fourth Circuit's previous standard for preliminary injunctions found in *Blackwelder Furniture Co. v. Selig Mfg. Co.*, 550 F.2d 189 (4th Cir. 1977)). The harm to be prevented must be of an immediate nature and not simply a remote possibility. *In re Microsoft Antitrust Litig.*, 333 F.3d at 527.

Plaintiffs submitted reliable evidence in the form of affidavits from their treating physicians and testimony of their current caregivers that supported their allegation that a reduction in services would cause dramatic changes in their current living conditions. Based on the physicians and caregivers' knowledge of Plaintiffs' needs, they attested that service reductions would lead to the need for institutional care. The Magistrate Judge noted these affidavits in her report in addition to detailing the possible consequences of placing Plaintiffs in an institution. The court finds that this evidence demonstrates that institutionalization is sufficiently likely; and therefore, the issuance of a preliminary injunction is warranted. Defendants would have the court wait until Plaintiffs are actually removed from their current living arrangements. However, the standard requires a finding of likelihood, not absolute certainty. Further, the harm to be prevented will have already been done should the court adopt Defendants' position to wait until the effects of the service reductions are certain.

Next, Defendants argue that the Magistrate Judge erred in finding a likelihood of success on the merits. Because a preliminary injunction grants relief on a temporary basis prior to trial, the party seeking the preliminary injunction must demonstrate that it is likely to succeed on the merits at trial by "a clear showing" and may not rest on merely the probability of success. *Real Truth About Obama, Inc.*, 575 F.3d at 345 (citing *Winter*, 129 S. Ct. at 376). The ADA prohibits states from discriminating against mentally disabled persons through unnecessary segregation. *Olmstead v. L.C.*, 527 U.S. 581, 600-02 (1999). Under the ADA, states are required to provide community-based treatment for persons with mental disabilities 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. *Id.* at 587.

In this case, the only dispute between the parties' concerns whether Defendants can reasonably accommodate Plaintiffs' community placement given the resources available to the State and the needs of others with mental disabilities. Plaintiffs submitted substantial evidence tending to show that the State has available resources to maintain the services required for Plaintiffs to remain in community placements. Plaintiffs have further submitted evidence that demonstrates the possibility that community placement will result in net savings to the State for the services required for Plaintiffs. The Magistrate Judge's report outlines this evidence in detail.

Based on the evidence in the record at this point in the litigation, Plaintiffs have a sufficient likelihood of success on the merits to support the imposition of a preliminary injunction.

Finally, Defendants urge the court to find that preliminary injunctive relief would cause harm to Defendants and to the public interest. In determining whether to allow injunctive relief, the court "must balance the competing claims of injury and must consider the effect on each party [and the public interest] of the granting or withholding of the requested relief." *Winter*, 129 S. Ct. at 376

(quoting *Amoco Prod. Co. v. Gambell*, 480 U.S. 531, 542 (1987)). However, Defendants provide the court with little argument regarding the possible harm they will suffer should the injunction be allowed. Defendants essentially claim that injunctive relief would undo the Amendment. Defendants ignore the fact that the very purpose of injunctive relief is to maintain the status quo while the merits of the case are litigated. If the court accepted Defendants' assertion of harm, the preliminary injunctive relief would never be appropriate. On the other hand, absent the requested relief, Plaintiffs are subject to a reduction in services at any time - despite the ongoing litigation over the legitimacy of the reduction. The possible harm to Plaintiffs in this case outweighs the possible harm to Defendants and the public interest will not suffer from temporarily requiring the State to do that which they claim they would voluntarily do anyway pending the resolution of this matter.

For the foregoing reasons, the court adopts the Magistrate Judge's Report and Recommendation [Doc. 71] and GRANTS Plaintiffs' Motion for Preliminary Injunction [Doc. 12]. Defendants shall maintain and/or return services in the quality, kind, and volume enjoyed by Plaintiffs prior to January 1, 2010, and, in the case of Peter B., prior to July 2009.

IT IS SO ORDERED.

s/ J. Michelle Childs
United States District Judge

March 7, 2011
Greenville, South Carolina

Exhibit 2

News Release of Comptroller Richard Eckstrom
reporting $225,945,013 in "lapsed" funds at SCDHHS

FILED

NOV 21 2011

SC ADMIN. LAW COURT

Richard Eckstrom
Comptroller General
of
South Carolina

News Release

WADE HAMPTON STATE OFFICE BUILDING, COLUMBIA SC 29201

August 20, 2010

FOR IMMEDIATE RELEASE

Contact: Jim Holly, 803-734-2588

General Fund Budget Turbulence Plagued FY10

The budget environment was uncertain throughout the fiscal year that ended June 30, 2010. Actual revenues trended down erratically for the year and they were $310.1 million less than the revenue projections used to generate the FY10 General Fund budget.

In a year of declining revenues, the state also incurred $40.2 million of unbudgeted spending through "open-ended" appropriations. Even though this spending hadn't been budgeted, it required funding. Making matters even worse, a $98.2 million operating deficit from FY09 was carried forward into FY10 with the hope that FY10 revenues would be available to pay it off.

To deal with these developments, the Budget & Control Board made $438.7 million in across-the-board cuts to agency budgets, avoiding even deeper cuts by drawing down $127.8 million from the Capital Reserve Fund to shield agency budgets. Through these and other drastic actions, the state avoided overspending and completed the year with a $71.0 million Budgetary General Fund surplus.

The General Reserve or "Rainy Day" Fund had been fully depleted in FY09 to partially offset FY09's operating deficit. To begin restoring the fund, the 2009-2010 Appropriations Act provided for a payment of $63.9 million (calculated at 1% of FY08 actual revenues) that was made July 1, 2009. In closing FY10, we restored an additional $46.9 million to the fund. The 2010-2011 Appropriations Act provided for a final payment of $55.4 million that was made July 1, 2010, thereby bringing the General Reserve Fund to FY11's full funding requirement (3% of FY 09 actual revenues of $5.5 billion).

The importance of having adequate reserve funds was made clear this year. I commend the General Assembly for submitting a proposed constitutional amendment to the voters this November to increase the Rainy Day Fund from 3% to 5% of General Fund revenues.

The current economic crisis has highlighted weaknesses in the state's efforts in forecasting and tracking revenue and in budgeting. More attention needs to be devoted to these areas so that the General Assembly will have a constant, comprehensive and reliable flow of data to make more informed decisions on short term, as well as *long range*, spending. A formal system for prioritizing all operating, as well as *capital*, expenditures needs to be developed to ensure that taxpayer dollars are spent wisely and effectively and not wasted on non-essentials.

The state can no longer postpone dealing with its obligation to fund retirement benefits for public employees. The severe funding deficit that exists needs to be dealt with immediately rather than passing it along to future generations.

These changes are needed for the state to live within its means, as prudent people and successful businesses would do in good economic times as well as the bad.

COMPTROLLER GENERAL'S OFFICE / (803) 734-2121
FAX / (803) 734-1765

State of South Carolina

BUDGETARY HIGHLIGHTS

BUDGETARY GENERAL FUND

Fiscal Year Ended June 30, 2010

Appropriations Act Budgeted Revenues for FY09-10	$ 5,552,002,165		
Actual Revenues	5,241,895,775		
Shortfall		$	(310,106,390)
Mid-Year Budget Actions of Budget and Control Board:			
Applied Capital Reserve Fund against Projected Revenue Shortfall -- June 2009	127,847,888		
Cut Agency Budgets 4.04 percent -- September 2009	200,452,112		
Cut Agency Budgets 5 percent -- December 2009	238,227,922		
			566,527,922
Closing Entries Directed by Statute or Proviso:			
To Cover "Open-Ended" Appropriations	40,244,804		
To Liquidate FY09 Operating Deficit Carried Forward to FY10	98,216,617		
To Replenish General Reserve Fund	46,959,511		
			(185,420,932)
Net Budgetary Surplus		$	71,000,600

BUDGETARY GENERAL FUND

Changes in Budgetary Fund Balance

Fiscal Year Ended June 30, 2010

	Reserved				
	General Reserve	Appropriations Carried Forward	Capital Reserve	Unreserved/ Undesignated	Total
Revenues	$ —	$ —	$ —	$ 5,241,895,775	$ 5,241,895,775
Expenditures	—	—	—	(5,117,133,571)	(5,117,133,571)
Transfer to General Reserve per Act	63,923,944	—	—	(63,923,944)	—
Transfer to Capital Reserve per Act	—	—	127,847,888	(127,847,888)	—
Appropriations:					
Brought Forward From Last Year [a]	—	(218,728,910)	—	218,728,910	—
Carried Forward to Next Year [b]	—	63,390,442	—	(63,390,442)	—
Capital Reserve Fund Applied Against Projected Revenue Shortfall	—	—	(127,847,888)	127,847,888	—
General Reserve Fund Restoration	46,959,511	—	—	(46,959,511)	—
Net Current Year Changes	110,883,455	(155,338,468)	—	169,217,217	124,762,204
Fund Balance–July 1, 2009	—	218,728,910	—	(98,216,617)	120,512,293
Fund Balance–June 30, 2010	$ 110,883,455	$ 63,390,442	$ —	$ 71,000,600	$ 245,274,497

[a] These represent current year expenditures that did not require current year budget appropriations.

[b] These represent current year budget appropriations that will not be expended until next year.

BUDGETARY GENERAL FUND

Revenue Analysis

Fiscal Year Ended June 30, 201(

	Actual Revenue	Budgeted Amounts[a] Original	Budgeted Amounts[a] Final	Actual Over (Under) Original Budgeted Revenue	Actual Over (Under) Final Budgeted Revenue	Actual 2009	2010 Actual Over (Under) 2009 Actual Revenue
Regular sources:							
Individual income tax	$ 2,170,909,624	$ 2,469,023,143	$ 2,037,184,407	$ (298,113,519)	$ 133,725,217	$ 2,326,707,698	$ (155,798,074)
Retail and casual sales tax	2,190,976,127	2,192,353,185	2,137,179,935	(1,377,058)	53,796,192	2,247,876,029	(56,899,902)
Corporation income tax	109,557,160	128,926,367	114,462,730	(19,369,207)	(4,905,570)	207,174,754	(97,617,594)
Total income and sales taxes	4,471,442,911	4,790,302,695	4,288,827,072	(318,859,784)	182,615,839	4,781,758,481	(310,315,570)
Insurance tax	158,647,299	173,600,092	173,650,092	(14,952,793)	(15,002,793)	172,882,640	(14,235,341)
Beer and wine tax	99,229,717	107,385,376	107,385,376	(8,155,659)	(8,155,659)	101,356,299	(2,126,582)
Corporation license tax	73,412,950	92,132,150	90,339,862	(18,719,200)	(16,926,912)	80,987,747	(7,574,797)
Departmental revenue	63,752,920	43,108,056	43,108,056	20,644,864	20,644,864	37,485,169	26,267,751
Alcoholic liquors tax	57,463,218	57,361,772	57,361,772	101,446	101,446	57,460,842	2,376
Earned on investments	41,706,507	67,000,000	51,000,000	(25,293,493)	(9,293,493)	79,559,729	(37,853,222)
Business license (tobacco) tax	35,257,195	28,000,000	28,000,000	7,257,195	7,257,195	30,572,978	4,684,217
Documentary (deed stamp) tax	31,003,309	37,966,115	37,966,113	(6,962,806)	(6,962,804)	24,406,393	6,596,916
Admissions tax	26,164,045	27,466,616	27,466,616	(1,302,571)	(1,302,571)	27,131,738	(967,693)
Public Service Authority (excess earnings)	18,587,646	16,340,234	16,340,234	2,247,412	2,247,412	20,589,881	(2,002,235)
Bank tax	15,672,134	7,425,001	7,425,001	8,247,133	8,247,133	8,493,851	7,178,283
Workers' comp insurance tax	12,944,957	14,655,680	14,655,680	(1,710,723)	(1,710,723)	12,779,422	165,535
Motor vehicle licenses	12,362,258	15,657,903	15,627,286	(3,295,645)	(3,265,028)	15,213,183	(2,850,925)
Aircraft tax	5,356,653	5,115,477	5,115,477	241,176	241,176	6,260,566	(903,913)
Private car lines tax	3,957,024	4,034,169	4,034,169	(77,145)	(77,145)	3,733,905	223,119
Savings and Loan Association tax	3,421,963	2,002,478	2,002,478	1,419,485	1,419,485	3,815,836	(393,873)
Coin-operated device tax	1,723,124	1,517,694	1,517,694	205,430	205,430	2,134,238	(411,114)
Retailers' license tax	799,436	883,722	883,722	(84,286)	(84,286)	788,790	10,646
Estate tax	72,908	—	—	72,908	72,908	152,850	(79,942)
Motor transport fees	875	10,000	10,000	(9,125)	(9,125)	6,899	(6,024)
Total regular sources	5,132,979,049	5,491,965,230	4,972,716,700	(358,986,181)	160,262,349	5,467,571,437	(334,592,388)
Miscellaneous sources:							
Indirect cost recoveries	16,085,383	16,679,391	16,679,391	(594,008)	(594,008)	16,101,492	(16,109)
Unclaimed property fund transfers	12,000,000	12,000,000	12,000,000	—	—	12,000,000	—
Circuit and family court fines	9,724,492	10,664,363	10,664,363	(939,871)	(939,871)	10,162,045	(437,553)
Mental health fees	3,400,000	3,200,000	3,200,000	200,000	200,000	3,400,000	—
Parole and probation supervision fees	3,392,808	3,392,808	3,392,808	—	—	3,392,808	—
Debt service reimbursements	535,600	188,108	188,108	347,492	347,492	1,144,988	(609,388)
Nonrecurring revenue[a]	63,778,443	13,912,265	13,912,265	49,866,178	49,866,178	30,400,000	33,378,443
Total miscellaneous sources	108,916,726	60,036,935	60,036,935	48,879,791	48,879,791	76,601,333	32,315,393
Total Budgetary General Fund	$ 5,241,895,775	$ 5,552,002,165	$ 5,032,753,635	$ (310,106,390)	$ 209,142,140	$ 5,544,172,770	$ (302,276,995)

[a] Budgeted amounts for Nonrecurring revenue have been reduced $225,945,013 pursuant to Proviso 90.13 and General Fund Reserve transfer per the Act.

BUDGETARY GENERAL FUND

Appropriations and Expenditures

Fiscal Year Ended June 30, 2010

Expenditures by Function	Appropriations Per Act	Adjusted Final Appropriations	Disposition of Adjusted Final Appropriations: Expenditures	Appropriations Carried Forward to 2011	Lapsed
Education	$ 2,115,037,477	$ 1,928,095,451	$ 1,919,706,182	$ 8,389,269	$ —
Health and Human Services	824,362,989	832,268,443	606,323,430	—	225,945,013 *
Higher Education	758,666,476	731,680,881	730,743,740	937,141	—
Corrections	330,008,029	327,998,422	327,998,422	—	—
Aid to Local Governments	270,637,611	280,659,011	280,606,059	52,952	—
Debt Service	190,480,976	197,273,917	194,729,243	2,544,674	—
Mental Health	176,001,571	161,432,735	161,432,618	117	—
Disabilities and Special Needs	164,605,147	150,839,580	150,807,394	32,186	—
Social Services	112,596,445	125,709,931	125,484,794	225,137	—
Health and Environmental Control	107,442,179	107,524,554	101,634,570	5,889,984	—
Juvenile Justice	91,578,671	88,556,726	88,261,905	294,821	—
Public Safety	59,277,788	56,503,551	55,328,082	1,175,469	—
Budget and Control Board	38,708,912	47,399,149	37,763,112	9,636,037	—
Revenue	35,933,851	35,933,851	35,933,706	145	—
Parks, Recreation and Tourism	26,181,564	35,555,330	30,577,724	4,977,606	—
Governor's Office	37,497,396	35,461,085	34,715,373	745,712	—
Judicial Department	25,013,593	22,791,352	22,782,531	8,821	—
Natural Resources	18,860,741	18,021,413	17,772,181	249,232	—
Commerce	5,889,854	17,818,921	7,104,646	10,714,275	—
House of Representatives	16,135,245	15,798,157	12,988,988	2,809,169	—
Probation, Parole, and Pardon	18,610,263	15,659,940	15,030,995	628,945	—
Senate	8,438,773	12,979,438	10,698,647	2,280,791	—
Educational Television Commission	12,911,437	12,087,252	12,054,771	32,481	—
Forestry Commission	13,251,379	12,080,563	12,076,137	4,426	—
School for Deaf and Blind	12,471,776	11,374,441	11,374,441	—	—
Vocational Rehabilitation	11,138,140	10,154,037	10,153,054	983	—
State Library	10,929,220	9,963,576	9,963,465	111	—
Commission on Indigent Defense	10,367,161	9,563,824	9,554,902	8,922	—
Prosecution Coordination Commission	10,304,400	9,393,962	9,344,505	49,457	—
Adjutant General	5,976,508	7,855,965	5,990,713	1,865,252	—
Alcohol and Other Drug Abuse Services	8,434,155	7,688,981	7,688,981	—	—
Legislative Support Agencies	5,123,495	5,720,085	5,329,946	390,119	—
Transportation	121,453	5,082,596	635,735	4,446,861	—
Attorney General	5,271,443	4,950,003	4,822,993	127,010	—
Election Commission	1,539,648	4,861,364	2,206,647	2,654,717	—
Aeronautics	—	3,952,703	2,510,700	1,442,003	—
Agriculture	4,296,189	3,916,602	3,916,602	—	—
John de la Howe School	3,418,831	3,511,470	3,459,294	52,176	—
Lieutenant Governor	3,471,300	3,460,402	3,201,323	259,079	—
Museum Commission	3,407,692	3,270,930	3,232,040	38,890	—
Archives and History	3,224,699	3,006,449	2,977,343	29,106	—
Wil Lou Gray Opportunity School	3,004,723	2,977,103	2,793,957	183,146	—
State Treasurer	2,031,130	2,822,099	2,822,099	—	—
Commission for Blind	2,861,096	2,733,306	2,634,376	98,930	—
Comptroller General	2,618,663	2,465,637	2,465,637	—	—
Arts Commission	2,691,819	2,453,987	2,452,387	1,600	—
Insurance	2,604,299	2,374,198	2,374,118	80	—
Workers' Compensation Commission	2,540,457	2,315,999	2,310,950	5,049	—
Labor, Licensing and Regulation	1,946,925	2,218,974	2,212,441	6,533	—
Consumer Affairs	1,641,852	1,496,788	1,496,788	—	—
Human Affairs Commission	1,590,952	1,459,623	1,449,818	9,805	—
Administrative Law Court	1,542,853	1,406,535	1,368,849	37,686	—
Legislative Audit Council	929,551	847,421	808,656	38,765	—
Secretary of State	753,536	686,958	686,958	—	—
Law Enforcement Training Council	572,518	521,934	521,874	60	—
Employment and Workforce	562,475	512,778	501,248	11,530	—
Commission for Minority Affairs	481,145	438,634	438,634	—	—
Sea Grant Consortium	444,756	405,460	404,575	885	—
State Ethics Commission	399,521	364,221	364,186	35	—
Procurement Review Panel	93,642	110,368	108,106	2,262	—
Capitol Police Force	1,238,858	—	—	—	—
Total	$ 5,586,175,346	$ 5,406,469,026	$ 5,117,133,571	$ 63,390,442	$ 225,945,013

* Health and Human Services appropriations lapsed pursuant to proviso 90.13.

BUDGETARY GENERAL FUND

Open-Ended Appropriations

Fiscal Year Ended June 30, 2010

Agency Name	Description	Amount
Open-Ended Appropriations: [1]		
Department of Corrections.....	Authorized Agency Deficit	$ 27,148,029
Adjutant General.....	State Active Duty Pay for Emergency Services	397,207
Budget and Control Board--Employee Benefits..	Workers' Compensation Insurance	49,914
Technical and Comprehensive Education Board	Proviso 18.1 - CATT Program	2,545,384
Aid to Subdivisions--State Treasurer.....	Aid to Counties - Mini Bottle Hold-Harmless	1,502,074
Aid to Subdivisions--State Treasurer.....	Aid to Fire Districts - Formula Funding Shortfall	1,844,071
Aid to Subdivisions--Department of Revenue.....	Aid to Counties - Homestead Exemption Shortfal	6,758,125
Total Open-Ended Appropriations		$ 40,244,804

[1] *"Open-ended" appropriations* result from Legislative commitments to fully fund certain budgetary items without providing sufficient appropriations to fully fund them or from any agency operating deficit if approved by the Budget and Control Board. In these instances, the State uses budgetary surplus at year end to fund appropriation shortfalls.

BUDGETARY GENERAL FUND

Appropriations Carried Forward to FY10–11

Fiscal Year Ended June 30, 2010

Agency	Total Carried Forward	Special Carry-Forwards	General Carry-Forwards	General Carryforward as % of Final Adjusted Appropriation
Election Commission	$ 2,654,717	$ 2,593,771	$ 60,946	4.22%
Commission for Blind	98,930	—	98,930	3.79%
Administrative Law Court	37,686	—	37,686	2.68%
Procurement Review Panel	2,262	—	2,262	2.65%
Employment and Workforce	11,530	—	11,530	2.25%
Museum Commission	38,890	15,383	23,507	.73%
Governor's Office	745,712	502,700	243,012	.71%
Human Affairs Commission	9,805	—	9,805	.68%
Commerce	10,714,275	10,680,850	33,425	.62%
Budget and Control Board	9,638,037	9,419,222	218,815	.60%
Natural Resources	249,232	152,906	96,326	.56%
Prosecution Coordination Commission	49,457	—	49,457	.53%
Debt Service	2,544,674	1,794,227	750,447	.39%
Labor, Licensing and Regulation	6,533	—	6,533	.37%
Lieutenant Governor	259,079	248,857	10,222	.32%
Educational Television Commission	32,481	—	32,481	.28%
Juvenile Justice	294,821	81,494	213,327	.26%
Education	8,389,269	3,862,613	4,526,656	.23%
Social Services	225,137	—	225,137	.22%
Sea Grant Consortium	885	—	885	.22%
Workers' Compensation Commission	5,049	—	5,049	.22%
John de la Howe School	52,176	46,598	5,578	.18%
Arts Commission	1,600	—	1,600	.07%
Higher Education	937,141	488,134	449,007	.06%
Health and Environmental Control	5,889,984	5,853,304	36,680	.04%
Forestry Commission	4,426	—	4,426	.04%
Disabilities and Special Needs	32,186	—	32,186	.02%
Aid to Local Governments	52,952	—	52,952	.02%
Parks, Recreation and Tourism	4,977,606	4,974,686	2,920	.01%
Public Safety	1,175,469	1,168,993	6,476	.01%
Law Enforcement Training Council	60	—	60	.01%
Vocational Rehabilitation	983	—	983	.01%
State Ethics Commission	35	—	35	.01%
Department of Insurance	80	—	80	.0%
State Library	111	—	111	.0%
Revenue	145	—	145	.0%
Mental Health	117	—	117	.0%
Senate	2,280,791	2,280,791	—	—
House of Representatives	2,809,169	2,809,169	—	—
Legislative Support Agencies	390,119	390,119	—	—
Legislative Audit Council	38,765	38,765	—	—
Judicial Department	8,821	8,821	—	—
Secretary of State	—	—	—	—
Comptroller General	—	—	—	—
State Treasurer	—	—	—	—
Attorney General	127,010	127,010	—	—
Commission on Indigent Defense	8,922	8,922	—	—
Adjutant General	1,865,252	1,865,252	—	—
Budget and Control Board-Capital Expenditure Fund	—	—	—	—
Wil Lou Gray Opportunity School	183,146	183,146	—	—
School for Deaf and Blind	—	—	—	—
Archives and History	29,106	29,106	—	—
Health and Human Services	—	—	—	—
Alcohol and Other Drug Abuse Services	—	—	—	—
Capital Police Force	—	—	—	—
Commission for Minority Affairs	—	—	—	—
Department of Corrections	—	—	—	—
Probation, Parole, and Pardon	626,945	626,945	—	—
Department of Agriculture	—	—	—	—
Consumer Affairs	—	—	—	—
Department of Motor Vehicles	—	—	—	—
Transportation	4,446,861	4,446,861	—	—
Aeronautics	1,442,003	1,442,003	—	—
Total	$ 63,390,442	$ 56,142,648	$ 7,247,794	.14%

[a] *Provisos contained within Part 1B of the FY09-10 Appropriations Act allow certain agencies to carry forward specific appropriation balances to FY10-11 for expenditure.*

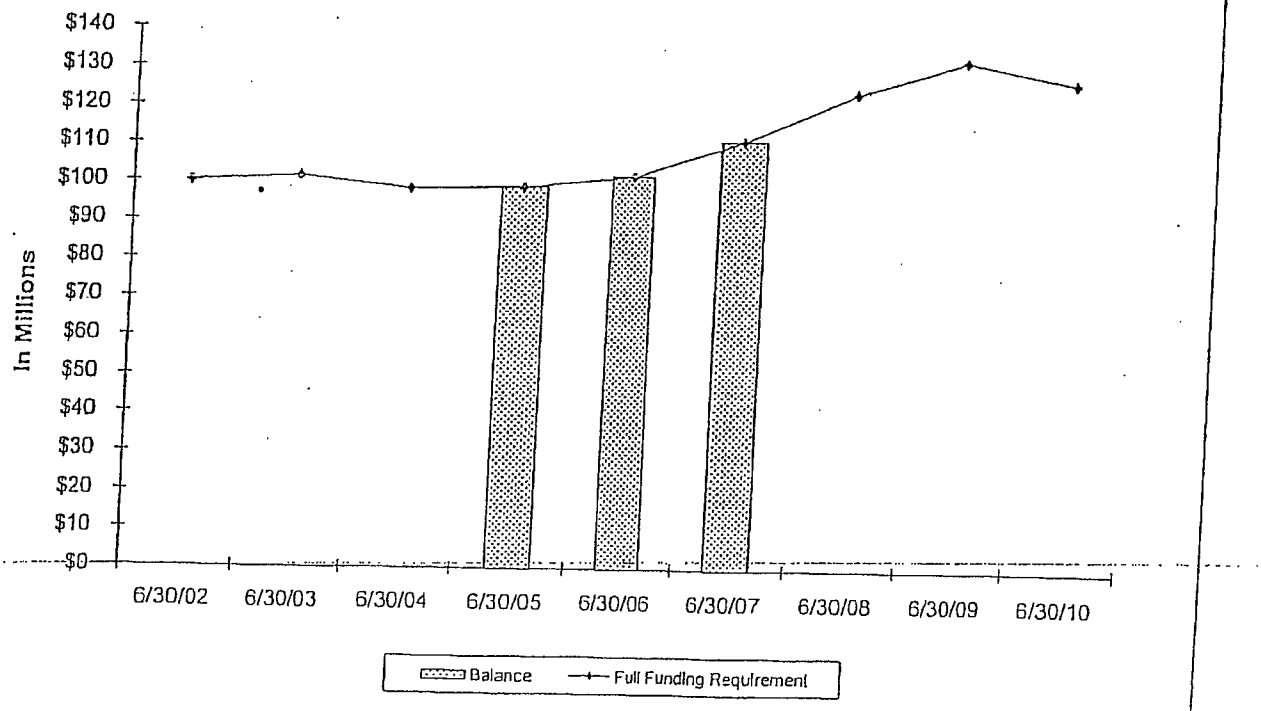
[b] *Proviso 89.28 of the FY09-10 Appropriations Act allows agencies to carry forward up to ten percent of their General Fund appropriations to FY10-11 for expenditure.*

Capital Reserve

BUDGETARY GENERAL FUND

Fiscal Years Ended June 30

Year	Beginning Balance	Appropriation	Amount Applied Against Revenue Shortfall	Used for Supplemental Appropriations	Ending Balance	Full Funding Requirement
2002	$ —	$ 100,134,739	$ (100,134,739)	$ —	$ —	$ 100,134,739
2003	—	101,606,475	(101,606,475)	—	—	101,606,475
2004	—	98,599,197	(98,599,197)	—	—	98,599,197
2005	—	99,356,026	—	—	99,356,026	99,356,026
2006	99,356,026	102,325,596	—	(99,356,026)	102,325,596	102,325,596
2007	102,325,596	111,821,213	—	(102,325,596)	111,821,213	111,821,213
2008	111,821,213	124,520,532	(124,520,532)	(111,821,213)	—	124,520,532
2009	—	133,170,058	(133,170,058)	—	—	133,170,058
2010	—	127,847,888	(127,847,888)	—	—	127,847,888



General Reserve

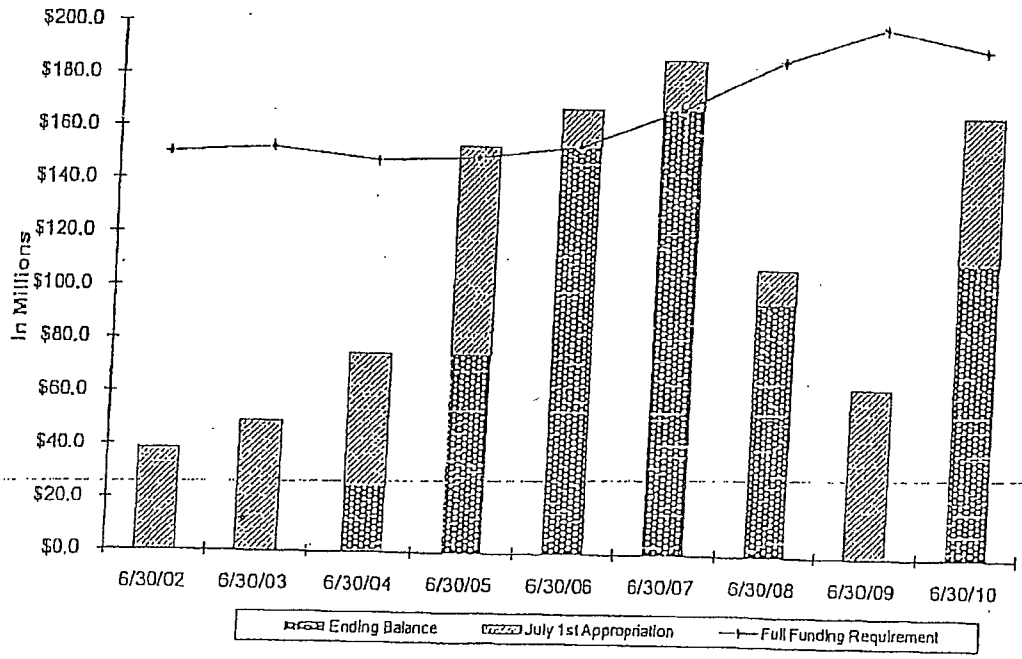
BUDGETARY GENERAL FUND

Fiscal Years Ended June 30

Year	Beginning Balance	Net Additions (Reductions)	Ending Balance[a]	Full Funding Requirement	Over(Under) Funded[b]	July 1st Appropriation[b]
2002	$ 60,523,390	$ (60,523,390)	$ —	$ 150,202,108	$ (150,202,108)	$ 36,797,374
2003	—	—	—	152,409,712	(152,409,712)	49,299,599
2004	—	25,154,528	25,154,528	147,707,970	(122,553,442)	50,000,000
2005	25,154,528	50,000,000	75,154,528	149,034,039	(73,879,510)	78,333,866
2006	75,154,528	78,333,866	153,488,394	153,488,394	—	14,243,425
2007	153,488,394	14,243,425	167,731,819	167,731,819	—	19,048,978
2008	167,731,819	(72,609,202)	95,122,617	186,780,797	(91,658,180)	12,974,290
2009	95,122,617	(95,122,617)	—	199,755,087	(199,755,087)	63,923,944
2010	—	110,883,455 [a]	110,883,455	191,771,831	(80,888,376)	55,441,728

[a] Includes July 1, 2009 contribution of $63,923,944 plus closing entries of $19,273,440 (per Proviso 90.15) and $27,686,071 to replenish General Reserve Fund to meet its reduced full funding requirement in FY11 ($166,325,183) after receipt of the July 1, 2010 contribution of $55,441,728.

[b] Ending balances in the table above do not reflect payments made on July 1 of any succeeding year as a result of appropriations to the General Reserve Fund. The graph below reflects the balances in the General Reserve Fund including these July 1 appropriations (cross check portion of the bars).



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.

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

THE STATE OF SOUTH CAROLINA
IN THE ADMINISTRATIVE LAW COURT

Appeal from the Division of Hearings and Appeals
South Carolina Department of Health and Human Services

Docket Number: 10-ALJ-08-0501-AP

S.E, J.W.E., M.M., and A.C.M.,

Appellants,

vs.

South Carolina Department of Health
and Human Services,

Respondent.

RETURN TO MOTION TO ALTER OR AMEND

Patricia L. Harrison
Attorney-at-Law
611 Holly Street
Columbia, South Carolina 29205
Office (803) 256-2017
Fax (803) 256-2213
plh.cola@sorldnet.att.net
ATTORNEY FOR APPELLANT

Richard G. Hepfer
Deputy General Counsel
Office of General Counsel
SC Department of Health and
Human Services
PO Box 8206
Columbia, South Carolina 29202
(803) 898-2791 voice
(803) 255-8210 fax
hepfer@scdhhs.gov
ATTORNEY FOR RESPONDENT

The Appellants in this matter have moved that the Order of the court in this matter be altered or amended for the following reasons, to which the Respondent replies:

I. First, the Appellants assert that the federal district court has now ruled on the preliminary injunction request in Peter B, et al. v. Sanford, et al. C.A. No.: 6:10-cv-00767-JMC.

It is true that the federal district court has now granted a Preliminary Injunction in the Peter B. case. Still, a Preliminary Injunction is not a final decision in the matter, and, in any case, would not preempt this State matter. In fact, we believe that it is more likely that the federal court would administratively abstain and defer to the State decision, for these Appellants, given that the State decision attempts to advance a rational administrative process for these types of cases. (Burford abstention after Burford v. Sun Oil Co., 319 U.S. 315 (1943)).

Furthermore, the federal court based its decision not on the issues decided by this court but on the notion that reduced services would not allow the Plaintiffs to remain in the community and thus could be violative of the Americans with Disabilities Act. This court decided this case on the Medicaid requirement to provide recipients with an opportunity for an evidentiary hearing under 42 CFR §431.200 et seq., when their benefits have been reduced, suspended or terminated.

II. The Appellants assert that the Departments have misrepresented the reasons for the reductions.

It is obvious in these economic times that all States are experiencing budgetary shortfalls. The Appellants submit additional documents that purport to show that transfer of unobligated funds to the General Assembly for redistribution. Appellant asserts that if the funds had remained with the Departments there would have more than sufficient funds to pay for the services they want.

If the General Assembly took money from the Departments' budgets, that is not something that

the Departments (or the Administrative Process) have the authority to remedy. Video Gaming Consultants, Inc. v. South Carolina Dep't of Revenue, 342 S.C. 34, S.E. 2d 642 (2000) and Drummond v. State Dept. of Revenue, 378 S.C. 362 (2008). Therefore, it is still correct for the Departments to assert a budget reduction. Furthermore, this issue was raised in the December 2009 Petition to the Supreme Court, which dismissed the matter.

III. Defective notice under 42 CFR §431.210

The Respondent also believes that this issue was abandoned by not having been legally argued. The Appellants' Brief, beginning at page 26, does set forth cogent arguments as to why an evidentiary hearing should be provided, and why these cases should not have been dismissed without hearings. The Appellants cite the South Carolina Constitution. The Appellants argue the Medicaid statute at 42 USC §1396a(a)(3) and the case of Goldberg v. Kelly, 397 US 254 (1970) cited in the Regulations at 42 CFR §431.205(d). Finally, the Appellants offers a number of reasons why Rosen v. Goetz, 410 F. 3d 919 (6th Cir. 2005), cited by the Respondent as an example of an instance in which no evidentiary hearings were required when a State reduced coverage, was not applicable to this case.

However, the Appellants did not offer any legal arguments as to why the Respondent's original Notice to the Waiver participants was defective. The Appellants did set forth, in their factual statement that insufficient notice was provided and any the notice was defective. The Respondent, in turn, did address the conundrum of the federal regulations requiring specific regulations in the appeal notice, when there seem to be no specific regulations (only very general ones) and it is much more meaningful that the Appellants received specificity from the DDSN Reconsideration determination and the Service Coordinators' communications. There was, however, no corresponding legal analysis in the Appellants' submissions.

IV The Appellants allege improper ex parte communication.

Since the Reconsideration rulings (for example, page 49, in the Edge Record) did not specify the specific reductions, it appears from the Edge Record at page 46 that the Chief Hearing Officer

requested a further explanation of the specific reductions imposed. Jacob Chorey responded with the specific reductions and the reasons for the reduction. In that way the Hearing Officer assigned to the case would be familiar with the agency action by which this Appellant was aggrieved.

Of course, we agree with the ALJ's Order that the actual Hearing Officers who decided the cases, were not involved in the ex parte communication, and the Chief Hearing Officer was simply trying to discharge his administrative duties as specifically allowed by the Judicial Cannons (3(B)(7)(a)).

As further authority for the Order, we cite Koon v. Fares 379 S.C. 150, 156, 666 S.E.2d 230, 234 (S.C.,2008), which held that a judge should disqualify himself in a proceeding in which his impartiality might reasonably be questioned. However, it is not sufficient for a party seeking disqualification to simply allege bias; rather, the party must show some evidence of bias or prejudice. *Id.* In this case, even if prejudice could be shown, the "judge" who conceivably might have engaged in ex parte communication did, in effect, recuse himself from the cases, by administratively assigning them to other Hearing Officers.

With respect to evidence outside the hearing Record, the Respondent is unable to see where that is alleged to have occurred.

V. Of course, we understand the court's Order in this matter and a copy of the Order has been forwarded to the Department's Appeals Division. We believe that hearings are now being scheduled, in accordance with the Order.

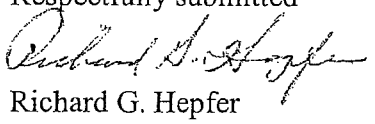
The operational side of the agency (besides the Appeals Division) remains somewhat uncertain as to the scope of the Order. We understand the plain language in the federal Fair Hearing regulations to require that the Department offer an opportunity for a hearing to anyone whose services have been reduced, suspended, or terminated. Still unclear is the level of specificity, if any, that Petitioners (before the Department's Appeals Division) must include in the appeal request, and otherwise, in order to properly avail themselves of that opportunity. For the time

being, in light of the recent ALC decisions in these matters, we hope the Appeals Division is erring on the side of granting a hearing, even if the basis of the appeal or even the agency action complained of cannot readily be determined by the appeal request.

Conclusion

The Order in this matter should stand without alteration or amendment. The Department will continue to seek guidance on what effort, if any, Beneficiaries must make to properly avail themselves of the opportunity for a hearing as set forth in the Medicaid regulations.

Respectfully submitted



Richard G. Hepfer
Deputy General Counsel
Office of General Counsel
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Voice: (803) 898-2791
Fax (803) 255-8210
hepfer@scdhhs.gov
Attorney for the Respondent

Columbia, South Carolina
November 30, 2011

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

APPEALS & HEARINGS
RECEIVED
JAN 03 2012
SCDHHS

RESPONDENT'S EXHIBIT
2

Office of General Counsel
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2795 Fax (803) 255-8210

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,

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

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.

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 these 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) seasonal 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,

Richard G. Hepfer
Deputy General Counsel
Office of General Counsel
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Voice: (803) 898-2791
Fax (803) 255-8210
hepfer@scdhhs.gov
Attorney for the Respondent

Columbia, South Carolina
December 29, 2011

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

TELEPHONE (803) 256-2017 FAX (803) 256-2213

February 27, 2012

Ms. Betsy Schlinder
Office of Appeals and Hearings
SC Dept. of Health and Human Services
1801 Main Street, Suite 901
Columbia, SC 29201

Re: Albert C. Myers
Case #11-MISC-302 (MR/RD)

Dear. Ms. Schindler:

Enclosed is our Rule 59(e) motion in the matter of A.C.M. v. SCDHHS. We are requesting that you advise immediately if you do not consider this motion to change the due date for filing a notice of appeal with the Administrative Law Court until 30 days after a ruling on this motion is received. We are also requesting a copy of the transcript.

I would appreciate your returning a clocked copy in the envelope which is being provided. Thank you for your attention to this request.

Cordially,

Patricia Harrison, by MCL

Patricia L. Harrison

cc: Richard Hepfer, Esquire
Mrs. Carolyn Myers

South Carolina Department of Health and Human Services
Office of Hearings and Appeals

In the matter of Albert Cooper Myers

Case No. 11-MISC-302 (MR/RD Waiver)

MOTION TO ALTER OR AMEND PURSUANT TO RULE 59(e)

Pursuant to Rule 59(e) of the South Carolina Rules of Civil Procedure, Appellant files this protective motion to alter or amend that judgment which was received by Appellant's counsel on February 16, 2012.

This motion is based on the following grounds, which may be amended, supplemented or modified in a statement of issues pursuant to S.C. Code Ann. §1-23- 380(A)(6) on appeal to the Administrative Law Court. The reason for not including all possible grounds is that a transcript of the hearing is not available to the Appellant and it must be ordered from DHHS. This transcript was requested on February 25, 2012 and the Director of the Office of Hearings and Appeals informed counsel that the transcript will not be available for 30 to 40 days, which will be after the period for filing a motion to alter or amend.

In the event that the agency intends to take the position that an appeal must be brought in the South Carolina Administrative Law Court within 30 days of receipt of the order being appealed (received on February 16, 2012), regardless of the pending motion to alter or amend, Appellant requests that the agency immediately notify Appellant's counsel of this position.

The grounds for this motion, which may be amended or supplemented upon receipt of the transcript, are as follows:

1. The hearing officer erred in failing to rule that the January 1, 2010 caps on services and elimination of other services were invalid *ab initio* because DDSN and DHHS have attempted to establish a binding norm without promulgating regulations which are required by the South Carolina Administrative Procedures Act.

2. The hearing officer erred in finding that nursing services are available to Appellant and failed to rule upon the Respondent's denial of Appellant's request for these services which were ordered by his physician.

3. The hearing officer erred in failing to rule upon Appellant's appeal of the reduction of Respite services, erroneously finding that up to 240 hours would be available to Appellant.

4. The hearing officer failed to rule upon Appellant's objections that the change from annual allocations to monthly or weekly allocations, which constituted a reduction in services.

5. The hearing officer erred in failing to rule upon Appellant's appeal of the reduction in PCA services, erroneously finding that PCA services had not been reduced and ignoring the fact that the number of hours ordered by Appellant's physician have never been provided, resulting in the institutionalization of the Appellant.

6. The hearing officer erred in interpreting the decision of the Administrative Law Court as holding that *Hickey v. DHHS* allows implementation of the January 1, 2010 caps as binding norms if an evidentiary hearing is

provided.

7. The hearing officer erred in finding that PCA and Respite services are available "in sufficient amount to cover the Petitioner's daily needs" because there is no credible medical testimony in the record to contradict the orders of Appellant's treating physician as to his need for these services in the amount ordered by this physician.

8. The hearing officer erred in concluding that the failure to provide the number of hours ordered by Appellant's physician did not constitute a reduction in care, but only a "reconfiguation" of services.

9. The hearing officer erred by failing to rule upon Appellant's argument that the Respondent has violated the South Carolina Medical Practice Act by allowing treatment decisions of licensed physicians to be overridden by non-physicians.

10. The hearing officer erred in failing to rule upon Appellant's arguments that Respondent has violated the reasonable promptness, sufficiency, notice and reasonable standards requirements of the Medicaid Act.

11. The hearing officer erred because she failed to consider the elements a court must consider in determining whether an agency has violated the "Integration Mandate" of the Americans with Disabilities Act. The hearing officer's conclusory finding that the ADA and the United States Supreme Court's orders in *Olmstead v. L.C.* have not been violated are not supported by the record and it was legal error not to provide a basis for

that ruling.

12. The hearing officer erred as a matter of fact in determining that Appellant's caregivers testified that his needs can be met by the "new waiver." This is because the caregivers testified that Appellant's needs are not met by the number of hours provided before the reductions in services which were implemented on January 1, 2010.

13. The hearing officer erred in her factual finding that Appellant's needs less than 7 hours a day of PCA services and that Respite services are an adequate substitute for PCA services.

14. The hearing officer erred by failing to consider the arguments that Respite providers are increasingly unavailable due to the low rate paid for these services, in violation of 42 U.S.C. § 1396a(a)(30).

15. The hearing officer erred in finding that the threatened reduction in services and the failure to provide the services determined by Appellant's treating physician to be medically necessary did not force Appellant into an institution.

16. The hearing officer erred in finding that there was no evidence of retaliatory conduct on the part of the Respondent.

17. The decision that Respondent had the authority to reduce and eliminate services without promulgating regulations contradicts the holding of the Administrative Law Court.

18. The hearing officer erred as a matter of fact and law in determining that

Respondent has not violated the anti-retaliation provisions of the ADA.

19. The hearing officer erred as a matter of law and fact by failing to give appropriate deference to the opinions of Appellant's physician.

20. The hearing officer erred as a matter of fact and law by ignoring Appellant's objection to the Respondent erred as a matter of law and fact in its PASSAR determination which determined that Appellant does not require specialized services and in failing to provide those specialized services which would be provided in an ICF/MR.

21. Respondent erred as a matter of law by violating 42 USC 1396(a)(3) and the fair hearing regulations contained in 42 CFR 431 et seq. because the notice of termination/reduction of services was defective and the agency failed to comply with the promptness standards contained in federal law.

22. Respondent erred as a matter of law by violating the due process rights of the Appellant.

23. Respondent erred as a matter of law and fact because the findings of the agency and the hearing officer were arbitrary and capricious and not supported by the evidence or the testimony presented at the hearing.

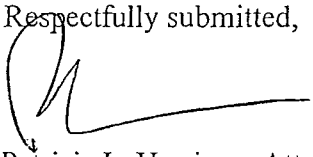
24. The hearing officer erred in finding that there are sufficient resources in the community available despite the imposition of the January 1, 2010 caps.

25. The hearing officer erred in failing to rule upon Appellant's claims that the ex parte communications between the Office of Hearings and Appeals and

DDSN were improper and that they violated the Appellant's right to due process.

Pursuant to Rule 59(e), Appellant respectfully requests that this tribunal reconsider and alter and/or amend its decision.

Respectfully submitted,



Patricia L. Harrison, Attorney for Albert Cooper Myers
611 Holly Street
Columbia, South Carolina 29205
plh.cola@att.net

February 26, 2012

Columbia, South Carolina

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF HEARINGS AND APPEALS

A.C.M,
Petitioner,

v.

South Carolina Department of Health and Human Services,
Respondent.

Case #11-MISC-302 (MR/RD)

CERTIFICATE OF FILING AND SERVICE

I, Nancy C. Law, Assistant to Patricia L. Harrison, Attorney for Petitioner, certify that I filed one copy of the foregoing *Rule 50(e) motion* with the SC Dept. of Health and Human Services, Office of Appeals and Hearings, by hand delivery on this 27th day of February, 2012. I further certify that I have this day, February 27, 2012, served one copy of the *Rule 50(e) motion* by hand delivery on counsel of record:

Richard Hepfer, Esquire
SC Dept of Health and Human Services
1801 Main Street
Columbia, SC 29202-8206

Nancy C. Law, Assistant to
Patricia L. Harrison

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.	)	RETURN TO MOTION TO ALTER OR AMEND 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

We agree that the Motion should extend the time for filing an appeal in the Administrative Law Court.

The Petitioner in this matter has moved that the Final Administrative Decision in this matter be altered or amended for the following reasons, to which the Respondent replies:

I. First, Citing the case of Hickey v. SCDHHS, 10-ALJ-08-0656-AP, the Petitioner asserts in items 1, 6, and 17 that the Hearing Officer failed to rule that the reductions were void *ab initio*, that the caps are an impermissible binding norm and promulgating the caps as a regulation is required before they can be enforced.

The Hearing Officer discussed the ALC case of Hickey v. SCDHHS, 10-ALJ-08-0656 and Doe v. SCDHHS, No. 27083 (SC, 2011) and determined, properly, we believe, that the Hickey case does not prevent the Department from enforcing the Waiver limitations if an evidentiary hearing is provided and that the Doe case does seem to allow the State, by

WL 6821502. Therefore, the limits can be enforced, especially when buttressed by competent testimony about the factual situation.

2. Secondly, the State does have a role in controlling the utilization of services, and although the attending physician's determination should be given great weight in determining services within the specified limits of the Waiver, the physician's determination is not dispositive. See Moore ex rel. Moore v. Reese, 637 F.3d 1220 (11th Cir. 2011).

IV. In item 10, and in part of item 21, the Petitioner asserts that the Hearing Officer failed to rule that the Department had violated the reasonable promptness provision and reasonable standards provisions of the Medicaid Act.

The services reduced or eliminated as a result of the Waiver renewal were continuously provided to the Petitioner during the pendency of the appeal, so we cannot see how the services at issue in this matter were not provided promptly. It further appears, based on the testimony of the Petitioner's caregivers that the care provided to the Petitioner met the standards set by the Departments and could be provided in sufficient amount duration and scope through the Waiver and State Plan to reasonably meet the Petitioner's needs.

V. In item 11, the Petitioner asserts that the Hearing Officer failed to break out the elements of the Olmstead case.

In Conclusion of Law #6, the Hearing Officer sets forth in great detail the services that are available to keep the Petitioner in the community, and, therefore, specifically finds that the Waiver reductions in the case of the Petitioner are not violative of Olmstead.

VI. In item 15 the Petitioner asserts that the Hearing Officer should have found that the lack of services forced the Petitioner to become institutionalized.

In Conclusion of Law # 6, the Hearing Officer detailed the services shown by testimony and documentary evidence to be available to support the Petitioner in the community.

Furthermore, in the Decision part of the Order, as shown by the testimony of the mother, the Hearing Officer also discusses her impression regarding one strong motive for the institutionalization. We believe that the Hearing Officer was correct in declining to find that the reduction in services did not in and of itself lead to the Petitioner's institutionalization.

VII. In items 16 and 18 the Petitioner asserts that the Hearing Officer erred in failing to find a retaliatory motive in the reduction of services and the prosecution of this case.

The Hearing Officer in conclusion of Law #7 fully discusses her reasons for not finding a retaliatory motive.

VIII. In item 20 the Petitioner asserts that the Hearing Officer erred in not finding that the Departments had erred as a matte of law in not carrying out a proper PASARR evaluation and determining that the Petitioner required specialized services.

We believe that the Hearing Officer properly declined to consider that argument as not having been initially raised in this appeal which was about the services provided to the Petitioner under the Waiver. Also, having entered the facility, the PASARR requirements now fall upon the nursing facility to implement. See, 42 CFR §483.315. The initial PASARR decision could have been appealed, but it could not properly be brought before the Hearing Officer in this case which deals with another issue which was appealed and remanded through numerous forums without mention of the PASARR provisions.

IX. In items 21 and 22 the Petitioner asserts that notice under 42 CFR §431 and promptness and due process was lacking.

As we understand the issues, this matter was about the reduction in services that occurred as a result of the Waiver renewal that was effective on January 1, 2010. In the ALC reversal of this matter, Judge Robinson found that the issue of notice had been

abandoned. See Page 13 of Judge Robinson's Order of November 9, 2011. Judge Robinson also ordered that to effect the reductions with respect to the Petitioner, the Department had to hold an evidentiary hearing which, we believe, satisfies the Petitioner's due process concerns. As to the promptness issue, see IV, above.

X. In item 23, the Petitioner asserts that the findings of the agency are arbitrary and capricious.

Obviously, we believe that the findings of fact are supported by the substantial evidence in the Record. The Findings of Fact, 1-11 in the Final Administrative Decision are based upon the testimony of the witnesses and the documents presented. This primarily consisted of the Petitioner's caregivers and the testimony of the Department's representatives about the services available within the Waiver. The findings are further explained in support of the Hearing Officer's Conclusion of Law #6, which in sub-items a through f details the services available through the Waiver.

XI. In item 25, the Petitioner complains that the Hearing Officer did not rule upon his claims of *ex parte* communication.

We believe that claim was dealt with in sufficient detail by the Administrative Law Judge beginning on page 11 of her November 9, 2011 Order. The ALC Order was before the Hearing Officer and it would not be proper to again rule on issues settled by the higher forum.

Conclusion

The Final Administrative Decision in this matter should stand without alteration or amendment.

SIGNATURE BLOCK ON NEXT PAGE

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

TELEPHONE (803) 256-2017 FAX (803) 256-2213

March 26, 2012

Mrs. Carolyn Myers
106 Hunt Cup Lane
Camden, SC 29020

Dear Carolyn:

Enclosed is the Hearing Officer's March 19, 2012, ruling on our Motion to Alter or Amend. We have 30 days to appeal. Please give Trisha a call at your earliest convenience.

Cordially,

Nancy C. Law, Assistant to
Patricia Harrison

South Carolina Administrative Law Court

In the Matter of Albert Cooper Myers v. SCDHHS

Case No. 11-MISC-302

Appeal of Decision of Betsy Schindler
from the
South Carolina Department of Health and Human Services
Office of Hearings and Appeals

Notice of Appeal

This appeal is taken pursuant to Rule 33 of the South Carolina Rules of the Administrative Law Court from a decision of the South Carolina Department of Health and Human Services Office of Appeals and Hearings.

The Appellant is Albert Cooper Myers. whose address is the Karesh Long Term Care Center, 1315 Roberts Street, Camden, South Carolina. The telephone number of his guardian is 803 475 5368. Mr. Myers is incapable of using a computer and does not have an email address. His attorney is Patricia Logan Harrison, whose address is 611 Holly Street, Columbia, South Carolina 29205. Her telephone number is 803 256 2017 and email address is plh.cola@att.net.

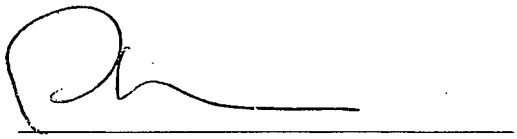
General grounds for this appeal are based on (a) violation of constitutional or statutory provisions; (b) the agency exceeding its statutory authority; (c) the decision being made upon unlawful procedure; (d) the decision being affected by other error of law; (e) the decision being clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record;

and (f) the decision being arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. These grounds for appeal may be amended, supplemented or modified in the statement of issues contained in Appellant's brief.

A copy of the Ruling on Motion to Alter or Amend and the decision on the appeal are attached. The Ruling on Motion to Alter or Amend was mailed on March 19, 2012 and was received on March 20, 2012.

A copy of the request for a transcript and the certificate of service is attached.

Respectfully submitted,



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

April13, 2012

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket 12-ALJ-08-0173-AP

Albert C. Myers, ...Appellant,

v.

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

APPELLANT'S BRIEF

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

ATTORNEY FOR APPELLANT

I. STATEMENT OF ISSUES ON APPEAL

Issue 1. **Were Myers' due process rights violated because Respondent's notices failed to comply with 42 C.F.R. 431.210(b), which required DHHS to inform Myers of "the reasons for the intended action"**

Issue 2. **Should this Court find legal error in Respondent's failure to identify the statute or regulation Respondent relied upon to support action taken pursuant to the Notices of Termination?**

Issue 3. **Were the communications between the DHHS Office of Hearings and Appeals and DDSN employee Jacob Chorey prohibited *ex parte* communications that should not be tolerated by the Court?**

Issue 4. **Did Respondent fail to promulgate the Medicaid service limitations at issue in this case as regulations under the South Carolina Administrative Procedures Act causing the caps to be unenforceable, null and void so that they could not be used as a basis for limiting Myers' requests for services his physician and therapists determined to be medically necessary?**

Issue 5. **Should the decision of the hearing officer be reversed because the decision of the agency that the services ordered by Myers' treating physician are not medically necessary is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record, the decision was arbitrary and capricious and characterized by the abuse of discretion and it was affected by error of law?**

Issue 6. **Were Myers and his guardian subjected to retaliation resulting from the advocacy efforts of Mrs. Myers in violation of the anti-retaliation provisions of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act and the Civil Rights Act?**

II. STATEMENT OF THE CASE

Myers filed this appeal with the South Carolina Department of Health and Human Services Office of Appeals and Hearings on February 1, 2010 requesting a fair hearing. Instead of providing Myers with an opportunity for a fair hearing, the hearing officer issued an "Interlocutory Order" requiring Myers to prove in a written response that he was entitled to a hearing. In his "Reply to Interlocutory Order" dated March 15, 2010, Myers identified the issues forming the basis for his appeal. R. at 240.

On May 6, 2010, the DHHS hearing officer dismissed Myers' appeal without providing him the opportunity for a hearing. R. at 225. Documents filed between May 6, 2010 and

November 9, 2011, appear to have been omitted by DHHS, and Myers requests that the Record be supplemented by the hearing officer to include all pleadings and orders in this case. On May 21, 2010, Myers filed a Motion to Reconsider the May 6, 2010 order. (Omitted from Record.) DHHS filed Cross-Motions to Dismiss Myers' appeal on September 24, 2010. (Omitted.) Appellant filed a Reply to this Cross Motion on October 12, 2010. (Omitted.) On October 29, 2010, Myers appeal was consolidated with that of three other MR/RD waiver participants whose requests for a fair hearing had also been denied. (Omitted.)

On November 9, 2011, the South Carolina Administrative Law Court reversed the decision of the hearing officer and ordered DHHS to provide each Applicant with an evidentiary hearing. R. at 216. Myers filed a Motion to Reconsider, raising issues upon which the Court did not rule. (Omitted.) A hearing was held on January 6, 2012. R. at 3. The hearing officer issued an order upholding the reductions to Myers' services on February 9, 2012, which was received by Myers' counsel on February 16, 2012. Id. On February 27, 2012, Myers filed a Motion to Alter or Amend. (Omitted). On March 8, 2012, DHHS filed a Return to this Motion. (Omitted). On March 19, 2012, the hearing officer issued an order denying Myers' Motion to Alter or Amend, which was received by counsel on March 20, 2012. (Omitted.) On April 13, 2012, Myers filed a Notice of Appeal with the South Carolina Administrative Law Court. (Omitted).

III. ARGUMENTS

Issue 1. Were Myers' due process rights violated because Respondent's notices failed to comply with 42 C.F.R. 431.210(b), which required DHHS to inform Myers of "the reasons for the intended action"?

42 C.F.R. 431.201(b) contains a very specific requirement that obligates the State to provide Medicaid participants with written notice describing the reasons for the agency's actions.

The right to receive Medicaid benefits is a property right which is protected by procedural due process. *Goldberg v. Kelly,* 397 U.S. 254 (1970) and *Hamby v. Neel,* 368 F.3d 549, 559 (6th Cir. 2004). The Due Process Clause of the United States Constitution requires Respondent to provide meaningful notice and an opportunity to be heard before an impartial tribunal before government benefits are denied. Id. and U.S. Constitution XIV Amended. The Constitution of the State of South Carolina provides that:

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

In this case, Respondent claims that a letter was sent to all MR/RD waiver participants in December 2009, but the DHHS witness in charge of the MR/RD program, Kara Lewis, testified that this was simply a "courtesy announcement.[1] R. at 101. The letter did not contain the information required by 42 C.F.R. 431.210 and there is no evidence in the Record that this "complimentary announcement" was actually sent to Myers. R. at 88. Lewis admitted that notices must include the reason for the action. Id. The Federal District Court of South Carolina dismissed Respondent's argument that reductions were necessary because of budget reductions. *See Peter B. v. Sanford*, Case No. 6:10-cv-00767 (D.C.S.C. March 7, 2011). See Record at page 1000. Judge Michelle Childs determined that the plaintiffs in *Peter B.*, appealing the same reductions at issue in this case, were likely to prevail at trial because they had submitted "substantial evidence" showing that the State has available resources to provide the services

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[1] Kara Lewis holds a BS with a "major in Health Care" from Appalachian State. R. at 98. She has no graduate or medical training.

necessary for plaintiffs to remain in the community. R. at 1000. Indeed, Judge Childs found that community placement of waiver participants would "result in a net savings to the State." Id.

On December 31, 2009, Myers' DDSN service coordinator signed documents identified as "Notice of Termination of Service." R. at 852 to 856. The Notices sent to Myers on or after December 31, 2009 included the following reasons for the State's actions:

Daily Respite	"Daily Respite is no longer covered under the MR/RD waiver." R. at 852
Hourly Respite	Decrease in services, cap in services by DDSN..."Respite Care has been cap to 68 hours per month and personal care has been cap to 28 hours per week." R. at 853.
Physical Therapy	"Physical Therapy will no longer be covered under the MR/RD waiver. R. at 854.

According to these Notices, the change in Myers' services did not result from changes in his needs and these forms did not indicate that the original request was not justified. R. at 852, 853, 854 and 856. (The first "box" on the form under the heading of "Reason.") The box indicating that Myers' "Medical condition has improved" was not marked. Id. The sole reason contained in the Notices sent to Myers was the caps that Respondent put into place in January, 2010, without promulgation of regulations. These caps were subsequently determined by this Court to be unenforceable, because they establish a binding norm without promulgation of regulations. R. at 295 (*Hickey v. DHHS*, Docket No. 10-ALJ-08-0656-AP, July 19, 2011) and R. at 279 (*Edge, Eubanks, Morgan and Myers v. DHHS,* dated November 9, 2011). In overturning Respondent's decision in another case that was based on a DDSN policy that was enforced for years by the agency without promulgation as a regulation, the South Carolina Supreme Court recently warned Respondent:

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

R. at 669. *Jane Doe v. DHHS*, South Carolina Supreme Court, December 28, 2011.

For a year, DHHS refused to provide Myers with a fair hearing and the hearing officer eventually dismissed his case. R. at 219. This Court reversed that decision and remanded Myers' appeal to DHHS.[2] R. at 279. But when Myers guardian arrived at the hearing that was finally scheduled a year after he requested an opportunity to be heard, Respondent introduced for the first time a novel and different "reason" for refusing to provide the services Myers' physician had ordered, i.e. that Respondent changed the definition of personal care services to eliminate supervision from the personal care services. R. at 22 and 23. This "reason" was not included in any of the notices sent to Myers or the other three appellants in the consolidated case. It was not contained in the "complimentary announcement" purportedly sent to all waiver participants in December 2009.

Ms. Priest testified that the cap on waiver services was implemented because "Most people could not tolerate being bathed, groomed, dressed, fed for that many consecutive hours."[3] R. at 23. To remedy this perceived problem, she testified that Respondent changed the definition

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[2] The order issued by the Administrative Law Judge was not an appealable order and Myers' right to appeal this issue was preserved by his filing a request for reconsideration.

[3] Ms. Priest holds a bachelor's degree in Social Work. She has no graduate training nor does she have any medical training. R. at 30.

of "personal care services" so that attendants could no longer provide "supervision." R. at 22 and 23. Ms. Priest confirmed that no one can receive more than 28 hours of personal care services:

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

R. at 33. Priest testified that no study was conducted prior to implementation of the reductions to determine whether rates paid for waiver services were high enough to enlist sufficient providers. The reasons relied upon by Respondent, according to the testimony presented at the fair hearing, were not included in the Notices of Termination sent to Myers in 2010, thus Myers was not provided "due notice" required by the Constitution of South Carolina or the "reasons" required by 42 C.F.R. 431.210(b). The failure to inform Myers of the reason for refusing to provide the services his doctor ordered was an error of law which must be corrected by this Court to prevent Myers and other vulnerable South Carolina citizens from continuing to be ambushed at "fair hearings." When the "reason" contained in the notice is different from the reason Respondent argued at the fair hearing, meaningful notice has not been provided. The notice in this case is clearly defective. Myers was denied the right to prepare his case to contradict the "reasons" argued at the hearing. He should not be required to guess, in preparing for the "fair hearing," what other new and different explanations the agency night present to the hearing officer.

The federal requirement to provide the appellant with the reasons for action taken by the State is especially important in administrative Medicaid appeals, where the affected person does not have the right to discovery nor does his counsel have the power to subpoena witnesses. This Court should consider whether the reasons set forth in the Notices of Termination support Respondent's changes. The federal regulation requiring Respondent to include the reason for the

denial is not optional. This legal error is subject to repetition, yet it evades review. If every time this issue is brought before the Court, the legal error is found to be "harmless" by the simple fact that this appellant found his way to the court house, the agency will have no incentive to change its illegal practices and legal rights of the neediest citizens of South Carolina will not be protected. Myers himself will likely be subjected to yet another appeal in the future and will be subject to another ambush by a new and previously undisclosed "reason" not known to him.

Issue 2. Should this Court find legal error in Respondent's failure to identify the statute or regulation Respondent relied upon to support action taken pursuant to the Notices of Termination?

For the same reasons, this Court should find that Respondent's notices were defective and in violation of federal law because they did not include the statute or regulation relied upon to support the State's action. Again, Myers and other MR/RD waiver participants have no right to discovery in administrative Medicaid appeals which is provided in other civil cases. It is undeniable that the Notices sent by Respondent do not contain the statute or regulation upon which the agency's decision was based. This is a clear requirement of 42 C.F.R. 431.210©, which unambiguously states that the notice must contain:

> The specific regulations that support, or the change in Federal or State law that requires, the action.

Ms. Lewis admitted at the hearing that the December 1, 2009 letter does not contain any reference to the law or regulations upon which the changes were based. R. at 100 and 101. She admitted Respondent's obligation to include the legal basis for the decision in the notice:

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

R. at 101. This legal error is subject to repetition, yet it evades review. The agency has not corrected its illegal practices after Myers called this violation to their attention. The hearing officer in this case, Betsy Schindler, found in another case involving DDSN termination of a waiver service that the agency's notice of termination was defective and in violation of 42 C.F.R. 431.210. *D.L.B. v. DHHS*, Appeals Case #11-MISC-156 (MR/RD Waiver) dated August 15, 2011. Once a State accepts federal funding, it must comply with all federal statutes, rules and regulations - this includes 42 C.F.R. 431.210©. *Doe v. Kidd*, 501 F.3d 348, 351 (4th Cir. 2007) (Citing *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). This Court should reverse the decision of the hearing officer and find that the Notices were defective because they violated 42 C.F.R. 431.210. The fact that Myers found his way to the courthouse and put up an unsuccessful challenge does not relieve Respondents of their legal duty to give him warning of the statutes and regulations the State would rely upon at trial. Had Myers known the legal basis for the action taken by Respondent he could have been better prepared to argue against the illegal acts taken by DHHS and DDSN. He was clearly prejudiced at the hearing by having to guess at the legal basis upon which Respondent relied to reduce, deny and terminate his Medicaid services.

Issue 3. Were the communications between the DHHS Office of Hearings and Appeals and DDSN employee Jacob Chorey prohibited *ex parte* communications that should not be tolerated by the Court?

Myers has alleged that the *ex parte* communications between Jacob Chorey and the DHHS Office of Hearings and Appeals constituted prohibited ex parte communications which indicated bias on the part of the tribunal. The record contains two *ex parte* memos sent by this DDSN employee to the director of the Office of Hearings and Appeals. These memos discuss the action taken by DDSN to reduce or terminate Myers' Medicaid services. The first was sent on

February 18, 2010, just one week after Myers' guardian sent the director of the Office of Hearings and Appeals his request for a fair hearing. R. at 259 and 260. A second *ex parte* memo was sent by Mr. Chorey to the director of the Office of Appeals and hearings on February 24, 2010. R. at 257. Neither of these memos were provided to Myers until after the hearing officer issued an order denying his request for a fair hearing.

Although the director of the DHHS Office of Hearings and Appeals is not an attorney and is not legally bound by the judicial code, his office has the same powers as a Court. His decisions in favor of his own agency put disabled persons in a position of having to overcome on appeal to the Administrative Law Court, where the presumption that the agency action is correct. The issues put before his hearing officers, who may or may not be attorneys, may involve matters of life and death for severely disabled appellants like Myers. Canon 2 requires judges to avoid all avoid impropriety and the appearance of impropriety. Canon 3B(7) provides that a judge shall not initiate, permit, or consider ex parte communications. Even magistrate judges, who deal with far less serious matters, can be sanctioned by the Supreme Court for *ex parte* communications with defendants. *In re Love*, 390 S.C. 310, 702 S.E.2d 115 (S.C. 2010). Fundamental fairness requires that DDSN simultaneously provide a copy of any memo it prepares for and submits to the DHHS Office of Hearings and Appeals to the waiver participant about whom the memo is written during an appeal. Myers requests an order finding that *ex parte* communications between the Office of Hearings and Appeals and DDSN violates the concept of Constitutional fundamental fairness. Indeed, an employee of an agency assigned to render a decision in a contested case may be convicted of a misdemeanor for communicating with and any person or party involved in the matter under consideration when this communication is without notice and an opportunity for all

parties to communicate. South Carolina Code of Laws Ann. § 1-23-360. The Administrative Procedures Act defines "agency" as "each state board, commission, department, executive department or officer..." Myers respectfully submits that this Court erred as a matter of law in finding that § 1-23-360 allows *ex parte* communications between employees of DDSN, a separate Commission which is governed by seven Commissioners, and members of the Office of Hearings and Appeals, which is a separate agency within the Governor's cabinet. To hold otherwise is to make a mockery of the "fair hearing" procedures and due process itself.

Issue 4. Did Respondent fail to promulgate the Medicaid service limitations at issue in this case as regulations under the South Carolina Administrative Procedures Act causing the caps to be unenforceable, null and void so that they could not be used as a basis for limiting Myers' requests for services his physician and therapists determined to be medically necessary?

The January 1, 2010 amendments to the MR/RD Medicaid Waiver have been treated as binding norms by the agency, as demonstrated by the responses of the Director of DDSN, DDSN's sole witness at the hearing, Myers' service coordinator and the DHHS employee who is responsible for the administration of the MR/RD Medicaid waiver program. In denying Myers' request for reconsideration, Dr. Beverly Buscemi, the Director of DDSN responded:

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

R. at 261. When asked who can decide to exceed the limits, DDSN's witness, Janet Priest responded that: "It's my understanding that no one does." R. at 33.

Priest is responsible for DDSN's operation of the MR/RD Medicaid waiver and she testified that DDSN and DHHS have not even discussed promulgating regulations. R. at 36-37. Myers DDSN service coordinator, Juanita Auker, was not aware of any regulations for the

operation of the MR/RD Medicaid waiver program and she testified that she relies on the DDSN manual instead to make service determinations.[4] R. at 77. When asked if she was aware of any regulations promulgated by the General Assembly for the operation of the waiver program, Auker responded "No." R. at 78.

Kara Lewis testified that service coordinators rely upon the MR Policy Manual written by staff at DDSN to determine what Medicaid services will be authorized. R. at 113. Lewis testified that she had discussed the promulgation of regulations only with "our Legal team," but admitted that "We didn't have any ideas." R. at 114. The Record contains the following exchange with Ms. Lewis about promulgating regulations:

Q. But you haven't done anything to promulgate regulations?
A. I have not.
Q. Okay, do you think that's necessary?
A. I don't know enough about it to give you an intelligent answer to tell you the truth.
Q. Okay. Have you talked about promulgating regulations with anybody at DDSN?
A. I haven't.
Q. Okay. So you haven't talked to anybody over there about whether or not they should promulgate regulations or you should promulgate regulations they'd have to comply with?
A. I haven't.

When asked about the lawsuit filed by South Carolina Protection & Advocacy asking the Court to require DDSN to promulgate regulations, Lewis denied knowledge of the lawsuit. R. at 115. She was clearly perturbed at the suggestion that DHHS had an obligation to promulgate

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[4] Auker holds a Bachelor's degree in psychology and a Master's in counseling, but she is not a licensed counselor. R. at 64. The Record contains no evidence that she has any medical training.

regulations, testifying that Myers' counsel was the only person who "keeps bringing this up in appeals." R. at 114. But she admitted that DHHS has done nothing to promulgate regulations in response to counsel's inquiries. Id. Lewis testified that she was not aware of the *Hickey v. DHHS* decision. R. at 104. She was also not aware that the South Carolina Administrative Law Court had determined in this consolidated case (Edge, Eubanks, Morgan and Myers) that the caps are unenforceable, because they were not promulgated as regulations. R. at 104. She also was unaware that the federal district court determined in the case of *Peter B. v. Sanford* that the January 1, 2010 reductions likely violated the Americans with Disabilities Act (ADA). R. at 105. Indeed, Lewis testified that DHHS did not consider whether the changes violated the ADA. Id.

In the first appeal to the Administrative Law Court in Myers' case, Judge Robinson adopted the holding in *Hickey v. DHHS*. Docket No. 10-ALJ-08-0656-AP, July 19, 2011. The holding in *Hickey* was that Respondent has treated the January 1, 2010 amendments to the MR/RD Medicaid waiver as an unenforceable binding norm. R. at 300. The language in Dr. Buscemi's denial letter to Myers was identical to the letter sent to Hickey, which is quoted in Judge Durden's order:

> [L]imits or caps were 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 Judge Robinson's order in Myer's case that was consolidated with Chip E., Michelle M. And Susan E., this Court determined that:

> ...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 he 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).

R. at 292.

Because the Respondent and the hearing officers have consistently treated the across-the-board reductions as binding, the failure of the agency to promulgate the rule as a regulation in accordance with the South Carolina Administrative Procedures Act renders it invalid and unenforceable. *Home Health Serv., Inc. v. S.C. Tax Comm'n*, 312 S.C. 328, 440 S.E.2d 375 (1994). When a challenged policy does not leave the agency the discretion to follow or not follow the policy at issue in a particular situation, and where the policy "so fills out the statutory scheme" that the agency will only look to whether the policy criteria are met in taking an action or rendering a decision, promulgation of the rule as a regulation is mandated by the Administrative Procedures Act. *Sloan v. S.C. Bd. of Physical Therapy Exam'rs*, 370 S.C. 452, 476, 636 S.E.2d 598, 610 (2006). Where there is a "close question whether a pronouncement is a policy statement or a regulation, the [agency] should promulgate the ruling as a regulation in compliance with the APA." *Sloan,* 370 S.C. 452, 475 (2006).

Since the waiver amendments were enacted in 2010, SCDHHS has treated them as a binding norm by which all waiver participants are bound, without exception to their individualized needs. The facts of this case do not contain a scintilla of evidence to support Respondent's new argument that the denials of services ordered by Myers' physicians were based

on an individualized assessment. No evidence from a qualified source was presented that contradicts the decision of Myers' treating physician that these services are medically necessary. Respondents' refusal to promulgate regulations is not a new phenomenon. In *Corbett v. SCDHHS,* the Respondent argued (unsuccessfully) that it was not necessary to promulgate regulations concerning its waiver program, despite the fact that the agency treated the agency's waiver manual as a binding document. No. 07-ALJ-08-0278-AP (July 16, 2008). This Court rejected that argument, finding that "CMS's approval of the State's Medicaid Plan or manual does not make it a binding document...[and] it must be promulgated as a regulation" to be considered as binding. Id.

The Administrative Procedures Act requires the agency to give public notice and to submit the proposed regulation to the General Assembly. South Carolina Code of Laws § 1-23-110 to 160. *See Sloan* at 474. It is indisputable in this case that Respondent failed to comply with these requirements and that the agency relied entirely and erroneously upon the fact that the Amendment was approved by CMS to support their assertion that the policy carries the force and effect of law. R. at 104. Auker's service coordination notes verify that she treated the caps as a binding norm and so informed Myers' guardian. R. at 858 to 876. In response to Myers' counsel asking Lewis if she was aware that this Court determined that the policy was invalid because it established a binding norm without promulgation of regulation, she answered: "No. What I'm aware of is that CMS has approved this and allows us to do it." R. at 104. Lewis was not aware of the case of *Peter B. v. Sanford,* where the federal district court determined that CMS approval does not trump the agency's obligations under the Americans with Disabilities Act. R. at 104. Ignoring this court order, Lewis testified:

> Our obligation is to submit a document that is acceptable to CMS and appears to meet the needs that will serve as many individuals within the MR/RD Waiver as possible...and we felt like that the document we prepared and submitted would do a very good job of that and it was approved with virtually no bullet back so we felt like we did a good job of it.

R. at 105. Other federal courts have agreed with Myers, finding that CMS approval of Medicaid waiver amendments do not overcome the obligation to comply with federal law. *Crabtree v. Goetz, No. 3:08-0930* , 2008 WL 5330506 at *30 (M.D.Tenn. Dec. 19, 20008) and *Pashby v. Cansler,* 5:11-cv-273-BO (NC DC Dec. 7, 2011).

Accordingly, since Respondent failed to comply with the Administrative Procedures Act, despite having been warned by this Court to do so, the cap on services is unenforceable, null and void and it cannot be used to deny services Myers' physician has determined to be medically necessary. *W. Carolina Reg'l Sewer Auth. V. SCDHEC*, Nos. 98-ACJ-07-0267-CC; 98-ALJ-07-0585-CC (Sept. 22, 1999). 1999 S.C. Env. Lexis 102. Myers will continue to be subjected to institutionalization so long as these arbitrary and legally unenforceable policies are applied without consequence. Respondent has what appears to be endless resource to litigate and bully into submission Myers, who is one of South Carolina's citizens least capable of protecting himself. Myers requests that this Court use its powers to enforce the law and to require Respondent to submit its illegal policies to public scrutiny and review by the General Assembly.

Issue 5. **Should the decision of the hearing officer be reversed because the decision of the agency that the services ordered by Myers' treating physician are not medically necessary is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record, the decision was arbitrary and capricious and characterized by the abuse of discretion and it was affected by error of law?**

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

opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference."527 U.S. 581, 561 (1999). According to Priest, the opinion of a waiver participant's treating physician is be weighed "like any information that we get from a teacher, from a parent, from a familiar caregiver." R. at 45. When asked how service coordinators are trained to weigh the opinion of a waiver participant's treating physician, she testified: "We don't tell them to weight it more heavily. We don't tell them to discount it. We tell them to consider it." R. at 45. Lewis testified that "We - we don't necessarily use medical criteria" for determining medical necessity. R. at 110. According to Lewis: "This Waiver is not based on medical necessity." R. at 111. She reported that service coordinators make treatment decisions by giving "equal weight to all of the information they would gather" to obtain a "holistic picture." R. at 111. She was not aware of regulations concerning medical necessity. Id. That was because DHHS does not base this waiver as a "medical model." R. at 112. She testified that the service coordinator talks with the family and puts the information "in a basket so to say" then proposes a plan and meets with her supervisor or the Executive Director of the local DSN Board. R. at 112. She "supposed" that the Executive Director could override the service coordinator. R. at 113.

The importance of the treating physician and other health care professionals in determining what treatment is medically necessary is also obvious from the legislative history of the Medicaid Act:

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

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

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

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

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

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

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

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

63 F.3d 418, 425 (5th Cir. 1995). This case cites 42 U.S.C. § 1396a(a)(17), as requiring the state plan to "include reasonable standards... for determining... the extent of medical assistance under the plan which are consistent with the objectives of [the Medicaid Act]"). 42 C.F.R. § 440.230(d) permits the state Medicaid agency to "place appropriate limits on a service based on such criteria as medical necessity". However, the state's standards must nevertheless be "consistent with the Act's objective of providing a broad range of health-sustaining services." Hope Med. Grp., 63 F.3d at 427-28.

For many reasons, the State is certainly not at the mercy of any physician who irresponsibly prescribes unnecessary treatment. When a State disagrees with the treating physician about whether a service is medically necessary, due process requires that a fair hearing be provided. 42 C.F.R. 431.200 et. seq. In *Moore v. Reese*, the Eleventh Circuit determined that a state may adopt a definition of medical necessity that places limits on the treating physician's

discretion. 637 F.3d 1220 (11th Cir. 2011). The state may also establish standards that individual physicians must use in determining what services are appropriate in a particular case and require treating physicians to operate within such reasonable limitations as the State may impose. Id. But Respondent has utterly failed to promulgate regulations to establish such limitations or a definition of medical necessity. In fact, Respondent has repeatedly ignored court orders finding that it must promulgate regulations before establishing binding norms such as the ones at issue in this case.

Undeniably, the State has a role to play in determining medical necessity, but reasonableness requires that the State's representative making the determination of medical necessity be qualified under the State's law to prescribe medical treatments. Respondent failed to present any opinion - or even a scintilla of evidence - from any qualified medical source to contradict the opinion of Myers' treating physician and physical therapist. According to the DDSN official who is responsible for the agency's operation of the MR/RD waiver program, only the service coordinator can authorize services. R. at 35.

Priest testified about a service coordinator going to a home and determining that "it was obvious that nobody understood the person." R. at 35. She testified that at some point "the physician *could* be involved...," but that the service coordinator had the power to "override" the physician's determination. R. at 36. According to Priest, the service coordinator is not "bound to comply with doctor's orders..." and that "There's no written criteria for that." R. at 42. Priest testified that "We don't determine medical necessity." R. at 43. She reported that "...the service coordinator is the one who assesses needs." Id. She said that "The service coordinator does an assessment of the need - does an assessment to determine what needs the person has and then

develops a plan or authorizes services to meets (sic) those needs." R. at 44. When asked if this practice complies with federal law, Priest responded again: "As I understand Waiver services, the service coordinator authorizes the services based on the assessment." Id. She did not know whether the federal government requires that services be medically necessary before Medicaid will pay for them. Id. Allowing a case manager to authorize or deny services clearly and undeniably contradicts federal regulations found at 42 C.F.R. 441.18(a)(6) which prohibit case managers from "exercising the authority to authorize or deny the provision of other services under the plan." These regulations instruct States not to allow case managers to "restrict an individual's access to other services under the plan." 42 C.F.R. 441.18(a)(2).

Thus Respondent's decision to deny the services Myers' physician ordered was not reasonable. In the event that the treating physician is not making a reasonable determination of medical necessity, the State's remedy is to present testimony from a medical practitioner with qualifications in the medical field at issue. But Respondent did not present a single piece of medical evidence to dispute the treatment decisions of Myers' treating physician, Dr. Munn. The hearing officer may even require the participant to submit to a medical assessment by an independent examiner when the examining physician's opinion is questioned by the State. 42 C.F.R. 431.240(b). However, what the State may not do is to base its decision upon a determination made by a person with no medical qualifications, as was the case in Myers' appeal. Such a determination would not be reasonable, based on federal case law, the Congressional intent shown in the legislative history of the Medicaid Act and the policies of the South Carolina Board of Medical Examiners. As recognized in *Rush v. Parham,* 440 F.Supp. 383, 389-90 (N.D.Ga.1977), a treating physician's treatment decisions are "governed by the standards and

ethics of his profession and by the dictates of federal and state law." *Id.* ; *see also id.* at 390 n. 12 (citing statutory criminal penalties for knowing or wilful misrepresentations in a Medicaid benefits application).

The Record contains credible and reliable evidence from Myers treating physician, Dr. Munn, supporting his opinion that Myers requires constant around-the-clock supervision. R. at 877. She determined that "with the necessary supports," Myers would be able to live in the community, and that the services he received before admission to the nursing home were "woefully inadequate." R. at 882 to 883. Witness Sandra Ray testified that Myers would be able to live in the community if the services ordered by Dr. Munn had been provided.[5] R. at 127. Dr. Munn determined that in order to live in the community, Myers required eight hours a day of nursing services on the days he was not attending a day program, due to his need to be fed through a feeding tube three times a day and to administer medications through this tube in the evenings. Id. She opined that "He is at a high risk for infection and rapid decline in his health if these services are not provided." Id. In addition to PCA services, Dr. Munn prescribed physical therapy and occupational therapy to prevent regression and to prevent contractures which would require surgical intervention. Speech services were also prescribed by Dr. Munn. Id. She determined that Myers needed a speech device that would allow him to communication by moving his eyes, since he is unable to use his hands or feet and a device that requires manual dexterity "would be of no use to Mr. Myers." R. at 882. The need for this device increased upon

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[5] The guardian ad litem appointed by the Probate Court in Myers' guardianship proceedings, Sandra Ray, holds a Master's Degree in Speech Pathology, a law degree, a Master's in Educational Leadership and holds a degree as an Educational Specialist. She has worked with people who have disabilities like Myers for more than twenty-five years. R. at 116. She worked for a national organization providing risk management for this population. Id.

entry to the nursing home, according to Dr. Munn.

Ms. Ray explained why Myers needs a speech device that would allow him to use eye gaze to control the device. R. at 118 to 121. According to Ray, this device would allow Myers to avoid hospitalization and described how being able to communicate would prevent skin break down that may result in dangerous decubitus ulcers. R. at 122 to 125. Lennie Mullis agreed that a speech device was medically necessary. R. at 133.

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

Dr. Munn determined that the failure to provide these services resulted in Myers be placed in a nursing home. R. at 880. She affirmed that:"If these services and supports that were ordered had been provided, including the number of hours of nursing and personal care attendant services determined to be medically necessary, it is likely that Mr. Myers would have been able to remain in the community in a less restrictive setting."Id. Ms. Mullis agreed that if the services Dr. Munn had ordered had been provided, Myers would likely have remained in the community and that his mother needed "many more hours" than DDSN authorized. R. at 143 to 144..

Dr. Munn determined that respite services are not an "acceptable alternative" to nursing and personal care services, because the rate of pay "does not attract the type of employee who has the capability to provide the supervision Mr. Myers needs." Id. Lennie Mullis testified about the "horrific shortage" of respite providers. R. at 140. According to Mullis: "there are very few respite providers because the reimbursement rate is so low that agencies, provider agencies do not want to take that on." R. at 142. She also testified about the risk DDSN requires families to

assume when they hire respite workers. R. at 141 to 142.

She expressed a medical need to received specialized services to allow Myers to communicate and his need for adult companion services. Dr. Munn determined that psychological services were needed twice each month "or more frequently if it appears that his condition is worsening." Id. This need for psychological services was confirmed by Myers' GAL, Sandra Ray. R. at 126 and 129. .Dr. Munn prescribed physical therapy for "at least one hour each week, or as determined to be medically necessary by a qualified physical therapist." Id. Dr. Munn agreed with the assessment performed by Myers' physical therapist, Darilyn Galloway-Coker. R. at 878 and 881. According to Dr. Munn, these physical therapy services were necessary to "prevent costly hospitalization which is likely to occur not only from contracture of his muscles, but from gastrointestinal and pulmonary disorders which are likely to result from worsening of his condition of scoliosis." R. at 881. Witness Lennie Mullis testified that Myers' physical condition has deteriorated over the last years and his scoliosis has "rapidly increased" for lack of therapy. [6] She described the risk of gastrointestinal blockage and pneumonia if the services ordered by Dr. Munn are not provided. R. at 133.

Dr. Munn ordered vision services to be provided through an annual eye exam. She opined that Myers needs to be put to sleep for dental services to be performed and that Myers risks infection which would lead to hospitalization if dental services are not provided. Id. According to Dr. Myers: "Poor oral status significantly increases the risk of developing respiratory infections, including pneumonia, in persons with developmental disabilities." Id. The

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

risks of failing to provide dental services at least twice a year were discussed by Lennie Mullis. R. at 135 to 136. She testified that "If you have a (sic) abscess or you have strep or if just have diseased gums, a gum disease, your whole body suffers from that..." Id.

Nothing in the records presented to the hearing officer by DDSN service coordinator Auker contradicts these medical opinions. R. at 858 to 876 and 884 to 891. Indeed, these medical records document the development of pressure sores that were not healing and an injury to Myers right arm, a clear worsening of his condition. On one of Auker's last entries, Auker also noted that Myers' scoliosis had increased. R. at 876. Yet Auker testified that Myers' request for nursing and additional PCA hours was denied because his condition had not changed. Aukers' testimony is not credible. Auker was paid by DDSN to provide "targeted case management," a service described in 42 C.F.R. 440.169. As such, she was charged with assisting Myers with obtaining services. Instead, Auker's records document that she was simply asking his mother if she had located providers for Myers. R. at 858 to 876. There is no indication in these records that Auker took any actions to schedule appointments to help him obtain needed physical therapy, dental or speech services (42 C.F.R. 440.169(d)(3). Auker was paid by Medicaid to help "link the individual with medical, social, and educational providers or other programs and services that are capable to providing needed services to address identified needs and achieve goals specified in the care plan. Id. She failed to assure that Myers' plan was "effectively implemented" and that it adequately addressed his needs. Indeed, Auker repeatedly informed Myers' guardian that the additional personal care services could not be provided, based on the caps. Her notes state that "they could not request more PCA II hours because Albert is already receiving over the cap amount due to the appeal." R. at 867. On July 14, 2011, Auker wrote in her notes that: "After

checking into the process and situation with Albert's (c) appeal SC discovered that Albert can not request any more PCA II hours due to him already being over the cap...no more units can be approved because he is already over the cap. Again on July 29, 2011, Auker wrote: "SC emailed Dawn Shealy, District I Program Manager to let her know SC was mailing information. She informed SC that no more hours could be approved until appeal was over." R. at 871. On August 10, 2011, Auker wrote that: "SC informed her that no more hours could be approved due to Albert going through the appeal." R. at 872. Auker documented Myers' request for nursing hours, but those were never provided. R. at 867. Auker informed Myers' guardian that nursing services cannot be provided on the same day that he receives five Adult Day Health Care services, another binding norm not promulgated as a regulation.

Auker documented discussion about Myers need for a communications device on September 15, 2011, but this device still has not been provided to Myers. R. at 874. In her testimony, Auker stated that she never authorized the speech device that Dr. Munn determined that Myers needed. R. at 73. She testified that she did not know what the restrictions were for Myers to obtain speech therapy. R. at 74 and 75. Auker admitted that she never authorized the nursing services ordered by Dr. Munn. R. at 77. When asked how she determined medical necessity, Auker testified that "I don't necessarily determine medical need. We go by our assessment and assess the needs that are there." R. at 79. She never spoke with Myers' physician, but just denied the hours he ordered. R. at 79 and 80. She "didn't give deference to anything," but claimed to have made her treatment decisions by looking "at the whole picture. R. at 81 and 82. When asked again what weight the orders of Myers' physician carried, Auker testified that "I wouldn't say that anything carried more weight than the other." R. at 93.

Auker testified that Myers continues to need physical therapy, psychological services and socialization, but she terminated his authorization to receive psychological services. R. at 84 to 87. DDSN did not consult Auker, Myers' physician, his mother nor his GAL before deciding that he has no need for "specialized services." R. at 86 to 87.

Medicaid services must also be provided with "reasonable promptness" pursuant to 42 U.S.C. 1396a(a)(8). Lewis testified that the "reasonable promptness" provision of the Medicaid Act required that services be provided within 45 or 90 days. R. at 109 to 110. Aukers' records document that she did not assist Myers' guardian in obtaining needed services. She simply noted in her records whether or not Myers' guardian had been able to independently obtain these services. It is obvious from the service coordination records that she acted simply as a gate keeper, which is prohibited by federal regulations. 42 C.F.R. 441.18 (a)(6) prohibits "providers of case management services from exercising the agency's authority to authorize or deny the provision of other services under the plan." The Fourth Circuit has upheld a South Carolina MR/RD Waiver participants right to receive services with reasonable promptness. *Doe v. Kidd I,* 501 F.3d 348 (4th Cir. 2007) and *Doe v. Kidd II,* 419 F.Appx. 411, **1 (4th Cir. 2011).

The standard established by Respondent is patently unreasonable. All of Respondent's witnesses testified that the agency's policy is for the decision to authorize or deny medical services is made by the DDSN service coordinator, who has no medical training and her notes confirm that she was being instructed to deny Myers' service requests based on the caps established on January 1, 2010. The only witness from DDSN state offices repeatedly admitted that she knew nothing about Albert Meyers: "I don't know anything about Mr. Myers' situation." R. at 45. One year after Myers filed his appeal, Priest did not know whether he was able to walk,

talk, bathe himself, prepare his own food or eat. R. at 48.

Issue 6. Were Myers and his guardian subjected to retaliation resulting from the advocacy efforts of Mrs. Myers in violation of the anti-retaliation provisions of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act and the Civil Rights Act?

Lennie Mullis testified that "People are very anxious, very, very anxious that if they complain too much they will lose the services they have. That is an overall concern by families." R. at 144. She testified that DDSN is "very arbitrary and capricious, no rhyme or reason how things are done." R. at 145. In *Barker v. Riverside County Office of Education,* the plaintiff was intimidated and constructively terminated by the school district because she complained that defendant was not in compliance with requirements of federal and state law in how it provided educational services to its disabled students. 584 F.3d 821, 823 (9th Cir. 2009). The Court found that the anti-retaliation provisions of the Rehabilitation Act grants standing even to non-disabled people who are retaliated against for attempting to protect the rights of the disabled. Id. at 825. As noted by the Court in Barker, Section 504 incorporates the anti-retaliation provision of Title VI of the Civil Rights Act of 1964 by providing that "...the remedies, procedures, and rights set forth in title VI of the Civil Rights Act of 1964 ... shall be available to *any person aggrieved by* any act or failure to act by any recipient of Federal assistance...." 29 U.S.C. § 794a(2) (emphasis added). The anti-retaliation provision of Title VI of the Civil Rights Act which is incorporated by section 504 states that:

> 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 that are 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." *Barker* at 825 citing *Weber,* 212 F.3d at 48 (*quoting* 34 C.F.R. § 100.7(e)) (*citing* § 104.61) (granting standing under section 504 of the Rehabilitation Act to a mother who claimed the school system had retaliated against her personally for attempting to enforce her disabled child's rights). Citing *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), the Ninth Circuit held that the ADA anti-retaliation provision also grants standing for harm resulting from advocacy efforts by a non-disabled person. The anti-retaliation provisions of Title II of the ADA state that:

> 1. (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 with Section 504 of the Rehabilitation Act, the language employed in the anti-retaliation provisions of Title II does not demonstrate a congressional intent to limit the protections of the ADA to cases where the acts of the disabled

person himself result in the retaliation. *Barker* at 827. The anti-retaliation provisions of the ADA recognize that persons with disabilities may need help from another non-disabled person to defend and vindicate their rights. Id.

When Mrs. Myers filed this appeal, DDSN threatened that parents would have to pay the State back for the cost of their adult children's services if they lost their appeals. R. at 176. Mrs. Myers organized a grass-roots organization called "South Carolina Voices" and became "communication central" by publishing a newsletter and sending daily emails informing parents across the State of their rights. R. at 174 and 175. She informed parents that they could not be held liable for the cost of adult children's services if the child lost his or her appeal. Id. She testified that people she talked with around the State are "very scared of retaliation." R. at 176. According to Mrs. Myers "It's a very real fear among parents" and she gave specific examples. Id. Parents in the Greenville area warned her that "...you really shouldn't be doing this." R. at 177. Mrs. Myers testified that her son never received the adaptive communications device or nursing services that were ordered by his physician and included in his plan of care. R. at 165. DDSN determined on the PASARR evaluation that her son did not need any "specialized services" when he was admitted to the nursing home, without even contacting Myers' doctor, guardian, GAL or DDSN service coordinator to determine his needs. ("Specialized services include things like physical therapy, dental services, psychological services, companion services, etc. *Voss v. Rolland,* 592 F.3d 242 (1st Cir. 2010). Respondent is refusing to pay for physical therapy services in the nursing home which are needed to prevent contractures. R. at 178.

When this Court reversed the Respondent's decision to deny Myers and three other waiver participants a fair hearing, DDSN did not pursue action to reduce or terminate the

services of the other three appellants. Myers guardian complained that only "ours was contested, yeah, I think there's some retaliation going on." R. at 182. Mrs. Myers was always fearful that DDSN would cut her son back to 28 hours and "that threat hanging over us that we might lose those hours." R. at 185.

IV. Conclusion.

Myers has presented credible medical evidence in support of the medical necessity of the services ordered by Dr. Munn. *Moore v. Cook*, No. 1:07-CV-631-TWT, 2012 WL 1380220, at *10 (N.D. *Ga.* .... June 19, 2012). For the reasons set forth above, Myers requests that this Court reverse the decision of the hearing officer and order the Respondent to provide all of the services that Myers' treating physician has determined to be medically necessary. In the alternative, Myers requests that this Court appoint an independent examiner pursuant to 42 C.F.R. 431.240(b). Myers requests an order requiring Respondent to pay attorney fees and costs.

Respectfully submitted,

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

Attorney for Appellant

August 2, 2012

South Carolina Department of
Health & Human Services

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

September 4, 2012

The Honorable Shirley C. Robinson, Judge
The S.C. Administrative Law Court
Edgar A. Brown Building
1205 Pendleton Street, Suite 224
Columbia, South Carolina 29201

Re: Albert C. Myers v. SCDHHS, Docket No. 12-ALJ-08-0173-AP

Dear Judge Robinson:

Enclosed are the original and one copy of the Respondent's Brief in this matter.

Please contact me if there are any questions or anything else is required at this time. My direct is (803) 898-2791.

Sincerely,

Richard G. Hepfer
Deputy General Counsel

Enclosure

cc: Patricia L. Harrison, Attorney for the Appellant

Office of General Counsel
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2795 Fax (803) 255-8210

THE STATE OF SOUTH CAROLINA
IN THE ADMINISTRATIVE LAW COURT

Appeal from the Division of Hearings and Appeals
South Carolina Department of Health and Human Services

Betsey Schindler, Hearing Officer

Docket Number: 12-ALJ-08-0173-AP

Albert C. Myers, Appellant

vs.

South Carolina Department of Health and Human Services, Respondent

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RESPONDENT'S BRIEF

Patricia L. Harrison
Attorney at Law
611 Holy Street
Columbia, South Carolina 29205
Office (803) 256-2017
plh.cola@att.net
ATTORNEY FOR APPELLANT

Richard G. Hepfer
Deputy General Counsel
Office of General Counsel
SC Department of Health and Human Services
PO Box 8206
Columbia, South Carolina 29202
(803) 898-2791 voice
(803) 255-8210 fax
hepfer@scdhhs.gov
ATTORNEY FOR RESPONDENT

RESPONDENT'S BRIEF

Statement of the Issues

1. Is there substantial evidence in the Record by which the Hearing Officer could determine that there was an adequate array of services available within the MR/RD Waiver for Appellant to be maintained in the community and avoid institutionalization?
2. Is the Hearing Officer's Decision affected by errors of law?

Background

The Appellant 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 reconfigured the Waiver services to include 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, 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 Appellant 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.

Procedural Posture

This case originally started as a Request for Reconsideration to the Director of the Department of Disabilities and Special Needs. The Appellant 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 Appellant 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 (the other ½ of the 8:30 to 2:30 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 Appellant:

1. Physical therapy services were eliminated from the Waiver.
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 and increase up to 240 in home hours based on the criteria described below. Based on the Appellant's situation, he received an increase in home-based respite to 101 hours per month (about 23 hours per week).
   (During the pendency of the appeal, the Appellant continued to receive PT, 101 monthly hours of Respite care, and 45 weekly hours of PCAII services. The other services – dental, medical care and supplies -- were initially unchanged.)
4. On or about January 12, 2011, the Appellant was authorized 6 hours per week of Personal Care Aide I services.
5. Following the 2011 Plan of Service meeting, the Appellant was authorized psychological counseling.
6. At some time after the original appeal, the Appellant elected to receive Adult Day Health Care in lieu of Day Services, but the time coverage was the same.

Adversely affected Waiver participants must first request a Reconsideration from the DDSN Director. The Appellant sought a Reconsideration of the changes. However, on January 13, 2010, the Director of DDSN upheld the changes. The Appellant 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 Appellant 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 Appellant Responded through counsel (Page 24 of the original Record on Appeal to the Administrative Law Court [ALC]) and the Respondent countered through counsel (Page 12 of the original Record). The Hearing Officer dismissed the matter (page 2 of that Record). At the ALC, the matter was consolidated with three (3) other similar matters, and, on November 9, 2011, this court 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 came back before the Appeals Division as a contested case. This court had ruled that 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 Appellant was afforded an evidentiary hearing

which took place on 1/6/2012. The Hearing Officer could not treat the reductions and limitations in the Waiver document as "binding norms," or matters of federal of state law.

Nature of the Action

This appeal, then, is from a contested case heard by the Department's Hearing Officer on 1/6/2012, as required by this court's previous remand of the matter for an evidentiary hearing.

Arguments

1) Scope of Review -- The "Substantial Evidence Rule"

Since the case is before the ALC as an appeal of an agency action, the ALC sits in an appellate capacity under the Administrative Procedures Act (APA), rather than as an independent finder of fact. In South Carolina, the provisions of the Administrative Procedures Act -- specifically S.C. Code Ann. §§1-23-600(E) and 1-23-380 -- require the ALC to apply the "substantial evidence" rule. Under that rule:

> (5) 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 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.

In applying the substantial evidence rule, the factual findings of the administrative agency are presumed to be correct. Hall v. Spartanburg County Counsel, 372 S.C. 420, 641 S.E. 2d 908 (Crt. App. 2007), citing Kearse v. State Health and Human Services

Finance Comm'n, 318 S.C. 198, 456 S.E.2d 892 (1995). The well-settled case law in this State has interpreted the rule to mean that an agency decision will not be set aside simply because reasonable minds may differ on the judgment. Lark v. Bi-Lo, 276 S.C. 130, 276 S.E.2d 304 (1981). Furthermore, the reviewing court is prohibited from substituting its judgment for that of the agency as to the weight of the evidence on questions of fact. Lee County School Dist. Bd. Of Trustees v. MLD Charter School Academy Planning Committee, 371 S.C. 561, 641 S.E.2d 24 (2007). 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. Substantial evidence is that which would allow reasonable minds to reach the agency decision. S.C. Coastal Conservation League v. S.C. Department of Health and Environmental Control, 383 S.C. 67, 610 S. E. 2d 482 (2005).

The party challenging an agency action has the burden of proving convincingly that the agency's decision is unsupported by substantial evidence. Waters v. South Carolina Land Resources Conservation Comm'n, 321 S.C. 219, 467 S.E.2d 913 (1996), citing Hamm v. AT&T, 302 S.C. 210, 394 S.E.2d 842 (1994).

Of course, the ALC may always reverse or remand a decision, which is affected by an error of law. Callahan v. Beaufort County School Dist., 375 S.C. 92, 651 S.E.2d 311 (2007). However, in reviewing the errors of law asserted by the Appellant, the ALC does need to give deference to the Department's interpretation of its own rules and the relevant federal rules and manual provisions applied. Hampton Nursing Center v. State Health and Human Services Finance Commission, 303 S.C. 143, 399S.E. 2d 434 (Ct. App. 1990).

2) There is substantial evidence in the Record that there was an adequate array of services available to the Appellant so that he could be maintained in the community:

Physical Therapy:

As cited in the Respondent's Prehearing Brief before the Appeals Division, the January 1, 2010 Waiver Renewal eliminated Physical Therapy (PT) as a Waiver service. However, 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.

As cited to the Hearing Officer, this reference is available on the Respondents website at: http://www.scdhhs.gov/internet/pdf/manuals/Physicians/SECTION%202.pdf

During the pendency of the appeal, the Appellant has 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 Appellant's attending physician prescribed the therapy to avoid hospitalization. See the Affidavit of the Appellant's treating physician, at page 881 of the 1/6/2012 Record.

Assistive Speech Device:

Although Speech Therapy per se is subject to the same restrictions as described above with respect to Physical Therapy, the Waiver document does include Specialized Medical Equipment, Supplies, and Medical Technology beginning at page 450 of the 1/6/2012 record. In addition, both Ms. Priest (page 34 of the Record) and Ms. Auker (page 73 & 74 of the Record) indicated that Speech Therapy was available outside of the Waiver on the same basis as Physical Therapy and Ms. Auker indicated that she had been talking with the Appellant's mother about an assistive speech device just before he went into the nursing facility.

Personal Care:

Personal Care Aide (PCA) I and Personal Care Aide II are described beginning at page 409 of the Record for the Remand hearing (1/6/2012). In her testimony beginning at page 22 of the 1/6/2012 hearing, Ms. Priest began her description of these services. Essentially, the PCA II service is an intensive hands-on service for the purpose of assisting a person with their activities of daily living (ADLs), like bathing, dressing, eating and toileting. PCA I services are appropriate for such tasks as housekeeping, laundry, cooking and shopping. The Waiver document at page 409 of the 1/6/2012 Record imposes a limit of 28 hours per week of PCA II services and 6 hours per week of PCA I services.

Beginning on page 25 of the 1/6/2012 Record, Ms. Priest testified about the use and limits on Respite services. Although Respite care providers are able to assist individuals with their ADLs when necessary, the primary purpose of the service is to provide care and supervision when the normal caregiver cannot be present. The waiver description of Respite Care begins at page 412 of the 1/6/2012 Record. Because heavy care of an individual is performed normally in the morning and evening hours, PCA services are limited as described, but Respite services are more liberally available -- up to 240 hours per month, depending on need. See the testimony of Ms. Priest at the top of page 26 of the 1/6/2012 Record. This would turn out to be an average of about 56 hours per week in the most difficult cases. The Appellant receives 101 monthly Respite hours or about 23 hours per week.

In Conclusion of Law #6, the Hearing Officer details her analysis of the sufficiency of services: Personal Care Aide Services and Respite Services were, based on the Waiver, testimony, and manual descriptions, found to be similar services although Respite service is a less intensive hands-on service, and less costly. In combination, the Hearing Officer found these services were adequate to meet the daily personal care needs of the Appellant as set forth in the description of the Appellant's daily routine as described by his personal care aide, Ms. Lisa Jones, beginning at page 149 of the 1/6/2012 Record. The Hearing Officer's finding with respect to the Appellant's daily routine is set forth in her Finding of Fact #5.

Adult Day Health Care Services:

Also in Finding of Fact #5, The Hearing Officer takes into account the five or six hour part of the Appellant's daily routine during which he was cared for in the Adult Day Health Care (ADHC) where he also received Adult Day Health Care Nursing which supports his mid-day tube feeding. He also is transported to and from the ADHC. These services are described in the Waiver document beginning at pages 407, 427 and 428 respectively. Ms. Auker, the Appellant's Service Coordinator, testified about the Appellant's daily use of ADHC, beginning at page 66 of the 1/6/2012 Record.

Psychological Service:

According to Ms. Auker, beginning at page 67 of the Record, and Ms. Mullis, beginning at page 138, the Appellant needed and, at some point after the initial appeal, was authorized to receive psychological services to deal with some grieving issues. These services are described in the Waiver document at page 449 of the Record.

Thus, every category of need presented by the Appellant was either being met or was available through the Waiver or through some other mechanism.

3) The alleged errors of law raised by the Appellant do not rise to a level that would require reversal.

The Services are Legally Sufficient

In the case of home and community based waivers services, the 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 Appellant. 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

Appellant's needs are completely or precisely met.

The Services were Adequate to Maintain the Appellant 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.

More Alternatives under the Waiver

Even if the Waiver services described by the Service Coordinator, Ms. Auker were inadequate (and we believe that the substance of her testimony is that the services were adequate), there were other alternatives under the Waiver. Ms. Priest, at page 58 of the 1/6/2012 Record, Ms. Auker, at page 94 of the 1/6/2012 Record, corrected by Ms. Lewis and further explained at page 95 of the 1/6/2012 Record talked about Residential Habilitation services. These services are described beginning at page 410 of the 1/6/2012 Record, and are provided in group home settings which offer 24 hour-a-day supervision. The supervision can be at more or less frequent time intervals according to the needs of the individual, but is not 24-hour-a-day one-to-one observation. This service is another of the array of services offered by the Waiver (listed in the waiver document at page 407 of the 1/6/2012 Record) to prevent or delay institutionalization.

Residential habilitation would be an alternative short of institutionalization that would be applicable if the Appellant's mother was no longer able to provide some of his care, such as his morning and evening tube feedings as she did before his admission to the nursing facility. See page 184 and following of the 1/6/2012 record. Also see the discussion beginning at page 187 of that Record, as to the declining ability of the Appellant's mother to provide some of his care.

Proper Limitations on Services are set forth in the Waiver Document:

It was never the intention of the Departments to offer 24-hour-a-day care to individuals who participate in the waiver. The first page of the Waiver document at page 359 of the 1/6/2012 Record contains this statement:

> 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.
> (Emphasis added)

As described above, the limitations on services are set forth in the descriptions of each service in the Waiver document. In Jane Doe v. SCDHHS, 398 S.C. 62, 74, 727 S.E. 2d 605, 611 (2011), the South Carolina Supreme Court seemed to indicate that Waiver provisions are enforceable with respect to the administration of the Waivers, even though Waiver provisions are distinguishable from promulgated regulations. In addition, the Department's promulgated regulations, at S. C. Code Ann. Regs. 126-300(D), may include, by reference, the Waiver approvals issued by CMS as federal directives. The regulation states:

D. Services are subject to limits and procedural requirements described in the South Carolina State Plan for Title XIX (Medicaid), provider manuals, Medicaid Bulletins, and federal directives.

The Limitations were not, in this Remand, Treated as a Binding Norm:

The Department does recognize that it is questionable whether an un-promulgated Waiver provision can be a "binding norm" upon a recipient of Waiver services. Even if the Waiver provisions are not be "rules of law," any denial based upon the Waiver document may be appealed for an adjudication of the issue. Previously, the Hearing Officer adjudicated and enforced the limitations without an evidentiary hearing. Based partially upon Hickey v. SCDHHS, Docket No. 10-ALJ-08-0656-AP, this court remanded the matter to the Department's Appeals Division for an evidentiary hearing. We believe that the holding in Hickey was not that the Waiver limitations are unenforceable, as asserted by the Appellant, but that they are not a binding norm and therefore may not be enforced without an opportunity for an evidentiary hearing. We do believe that the subsequent Jane Doe case, cited above, might allow the Waiver provisions to be enforced without an evidentiary hearing.

However, that should not be an issue in this case, because an evidentiary hearing was held on 1/6/2012, during which each side was able to present witnesses and evidence and cross examine witnesses presented by the other side. We would, therefore submit that Appellant's due process rights as established in Goldberg v. Kelly, 397 U.S. 254 (1970) as referenced in 42 CFR §431.205(d), and primarily relied upon by this court to remand the matter, have been met.

The Appellant had Adequate Notice of the Respondent's Position:

The regulation governing the content of notices is contained in 42 CFR §431.210, which says:

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.

(Emphasis added)

This matter was decided in the previous appeal in which this matter was remanded to the Department's Appeals Division. In that decision, the court said that that ground for appeal had not been preserved for appellate review and had been abandoned. By the time of the Remand hearing the Parties in this case had exchanged multiple briefs, motions and other filings. Surely by the Remand hearing it was clear that the original case was about the reconfiguration of the Appellant's services resulting from the new provisions in the January 1, 2010 Waiver Renewal.

Ultimately, the "regulations that support... the action" are set forth in the general description of the home and community based waivers in 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)

Obviously, that is a very general, over-arching and abstract concept, and, thus it is much more meaningful for a participant to be apprised of the particular service and service limits in the Waiver that apply to the particular action being taken by the agency. It is also much more concretely contestable than the general statement in the actual federal

regulations. Under the wording of the federal regulation at 42 CFR §431.210, it would have been permissible to simply have set forth the general statement in §440.180, referenced above. We submit that more productive notices are those that were referenced in the original Record. In fact, we suggest that a better interpretation of the common use of the term "regulation" in §431.210 is simply the rule that most precisely explains the action.

PASARR and Retaliation:

PASARR is the acronym for preadmission screening and annual resident review. As set forth in 1919(e)(7) of the Social Security Act [42 USC § 1396r(e)(7) and 42 CFR §483.100 et seq. the rule requires assessments designed to prevent inappropriate admissions to nursing facilities of individuals who are mentally retarded or who are mentally ill. In the event of admission, the PASARR evaluation ensures that, if capable of benefitting therefrom, the developmentally disabled or mentally ill resident receives appropriate active treatment in the facility.

Obviously this was not contemplated within the remand. Had the Respondent had some idea that this was an issue, the Departments could have produced witnesses to testify about the PASARR evaluation and the reasons for their decisions. Unfortunately, the Respondents did not at the commencement of the Remand hearing know that this was an issue, and were unprepared. Therefore, we must respectfully request that the PASARR matter not be an issue in this present case.

With respect to Retaliation, as we understand the Appellant's argument, it is that since he was the only one of the four originally remanded Appellants to have to go forward with a Remand hearing, he must have been singled out in retaliation for past activities. We believe that this allegation is adequately answered by Respondent's Exhibit #1, at page 278 of the 1/6/2012 Record. In this response to Appellant's counsel's' request to the Hearing Officer, the Department explains its' rational for not enforcing the Waiver limits in the other three (3) cases.

Conclusion

During his time in the community, the Appellant 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 personal care aide who also provided respite care. In April, that caregiver was injured while trying to lift the Appellant using the existing mechanical lift. The lift was replaced (page 71 of the 1/6/2012 Record). However, the paid 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 paid caregiver was injured, the Appellant began to receive psychological counseling for some depression due to the loss of the known caregiver. In December of 2011, the Appellant became a resident of 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 Appellant could have been maintained in the community as well or better than prior to the change in Waiver services. In renewing the Waiver, the Departments did not mean to simply reduce and eliminate services. The intent was to reconfigure the services to better meet the needs of the Waiver participants with previously little used or understood services. Although the new Waiver may lead to individual services being reduced, the Respondent's position is that it also leads to a richer mix of interventions for the active treatment of participants. See the range of services listed on page 407 of the 1/6/2012 Record and the descriptions that follow.

Therefore, the Respondent requests that this court affirm the Hearing Officer's Decision that:

1. The Department had the authority to implement the Waiver renewal reconfigurations;
2. There were sufficient services available under the new Waiver to maintain the Appellant in the community;
3. After litigating this case for so long the Appellant was aware of the reasons for the Respondent's original action; and

4. There were multiple factors that resulted in the Appellant's institutionalization.

Respectfully Submitted,

Richard G. Hepfer
Deputy General Counsel
Office of General Counsel
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Voice: (803) 898-2791
Fax (803) 255-8210
hepfer@scdhhs.gov
Attorney for the Respondent

Columbia, South Carolina
September 3, 2012

THE STATE OF SOUTH CAROLINA
IN THE ADMINISTRATIVE LAW COURT

Appeal from the Division of Hearings and Appeals
South Carolina Department of Health and Human Services

Docket Number: 12-ALJ-08-0173-AP

Albert C. Myers,

Appellant,

vs.

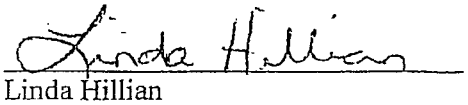
South Carolina Department of Health
and Human Services

Respondent.

CERTIFICATE OF SERVICE

I hereby certify that I am an Paralegal with the Appellant in the above-captioned matter and that on the 4th day of September, 2012, in Columbia, South Carolina, I served a copy of the forgoing Respondent's Brief on the following person by depositing the same in the United States Mail, postage paid, and addressed as follows:

Patricia L. Harrison
Attorney-at-Law
611 Holly Street
Columbia, SC 29205



Linda Hillian
Office of General Counsel
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Voice: (803) 898-2795
Fax (803) 255-8210

THE STATE OF SOUTH CAROLINA
In the Administrative Law Court

Appeal from the Division of Hearings and Appeals
South Carolina Department of Health and Human Services

Betsey Schindler, Hearing Officer

Docket No. 10-ALJ-08-0504-AP

Albert Cooper Myers,

Appellant,

v.

South Carolina Department of Health
and Human Services,

Respondent.

APPELLANT'S REPLY BRIEF

Patricia L. Harrison
Attorney-at-Law
611 Holly Street
Columbia, SC 29205
803-256-2017
plh.cola@att.net
ATTORNEY FOR APPELLANT

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket No. 10-ALJ-08-0504-AP

Albert Cooper Myers,.....Appellant,

v.

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

APPELLANT'S REPLY BRIEF

1. **Respondent violated the South Carolina Administrative Procedures Act and has disregarded the holdings of this Court which prohibited the State from enforcing the waiver caps without promulgation of regulations.**

Respondent in its brief, and the hearing officer in her orders, have twisted and turned the holding of this Court's order in *Hickey v. DHHS*, thereby committing an error of law. Docket No. 10-ALJ-08-0656-AP. Ignoring *Hickey* and the findings of this Court on remand in this case, Respondent claims on page 13 of its brief that it is "questionable" whether an unpromulgated waiver provision can be a "binding norm." That question has been asked and clearly answered by this Court and by the South Carolina Supreme Court in *Jane Doe v. DHHS*. 398 S.C. 62, fn. 7, 727 S.E.2d 605 (S.C. 2011). There is nothing in this Court's orders that suggests that Respondent may legally enforce the binding norms enacted in 2010, or for that matter, any rules not promulgated as regulations, to establish a ceiling above which no increases in services may be approved where there is a documented medical necessity for the services.

In *Hickey* and in *Edge/Eubanks/Morgan/Myers v. DHHS,*(hereinafter referred to as the "Consolidated Case") the central issue was whether Respondent erred as a matter of law by denying requests for services based on the MR/RD Medicaid waiver amendments at issue in this case without promulgating regulations. Docket No. 10-ALJ-08-0501. This Court clearly and unambiguously instructed Respondent in *Hickey* and the Consolidated Case that those reductions or denials of services may not be enforced as binding norms unless and until they promulgate regulations. Id. Respondent's admission, through Dr. Buscemi's declaration and the testimony of Kara Lewis, the DHHS official in charge of the MR/RD Medicaid waiver program demonstrate that the agency has no intention of promulgating regulations. Transcript at 101 (testimony of Kara Lewis). Ms. Lewis, Ms. Priest (DDSN official in charge of administration of the waiver) and Ms. Auker (DDSN Service Coordinator) all admitted that the denial of services at issue in this case was not based on regulations. (Transcript at 23, 64-66 and 88.) The agencies flaunt this Court's order in complete disregard of the authority of the judicial branch, or to the damage being inflicted to the most impoverished and disabled persons in South Carolina.

The doctrine of collateral estoppel prevents the agency from relitigating the issue of whether they can enforce the caps without promulgating regulations. As the South Carolina Court of Appeals recognized in *Carolina Renewal, Inc. V. South Carolina Department of Transportation:*

> Collateral estoppel, also known as issue preclusion, prevents a party from relitigating an issue that was decided in a previous action, regardless of whether the claims in the first and subsequent lawsuits are the same. *Judy v. Judy,* 383 S.C. 1, 7, 677 S.E.2d 213, 217 (Ct.App.2009). The party asserting collateral estoppel must demonstrate that the issue in the present lawsuit was: (1) actually litigated in the prior action; (2) directly determined in the prior action; and (3) necessary to support the prior judgment. *Beall v. Doe,* 281 S.C. 363, 369 n. 1, 315 S.E.2d 186, 189-90 n. 1 (Ct.App.1984). " While the traditional use of

> collateral estoppel required mutuality of parties to bar relitigation, modern courts recognize the mutuality requirement is not necessary for the application of collateral estoppel where the party against whom estoppel is asserted had a full and fair opportunity to previously litigate the issues." *Snavely v. AMISUB of S.C., Inc.*,379 S.C. 386, 398, [385 S.C. 555], 665 S.E.2d 222, 228 (Ct.App.2008).

Case No. 4622. Court of Appeals of South Carolina, October 8, 2009. In *Hickey*, the Respondent had the full and fair opportunity to litigate the issue whether the waiver caps could be enforced without promulgating regulations. This Court directly determined that the caps are unenforceable, because they establish a binding norm, requiring promulgation of regulations under the South Carolina Administrative Procedures Act. The determination of the enforceability of the agency rules capping services was necessary to support the judgment in *Hickey*. Thus, Respondent is prohibited from relitigating the issue of the enforceability of the waiver caps. As this Court held in *Hickey*: In determining whether an agency policy establishes a binding norm, the court will look at the actions of the agency "not to the labels given by the agency." *Hickey* at 6. Not only did the agency's adoption of a new and totally different reason for reducing A.M.'s services violate his right to notice, the label given by the agency (i.e. the reduction was due to a change in definitions of service categories) does not provide a legitimate basis for failing to promulgate regulations.

The testimony of officials of DDSN and DHHS, and the testimony of the DDSN service coordinator, confirms that the agency has still not changed the policies and practices which this Court has repeatedly determined to be illegal. In *Hickey*, this Court held that "Since the agency has consistently held the caps as a binding norm, they are unenforceable without promulgation of regulations." Id. at 6. Respondent's admission, through Dr. Buscemi's declaration and the testimony of Kara Lewis, the DHHS official in charge of the MR/RD Medicaid waiver program

demonstrate that the agency has no intention of promulgating regulations. Transcript at 101 (testimony of Kara Lewis). Ms. Lewis, Ms. Priest (DDSN official in charge of administration of the waiver) and Ms. Auker (DDSN Service Coordinator) all admitted that the denial of services at issue in this case was not based on regulations. (Transcript at 23, 64-66 and 88.)

The following exchange is contained on page 20 of the Transcript:

HARRISON:	Okay. Now when DDSN, these changes, can the service coordinator decide to exceed those limits?
PRIEST:	It is my understanding that when a limit is written into the Waiver, that is the limit that the Waiver funds.
HARRISON:	Okay, so who can decide to exceed the twenty-eight hours a week personal care attendant? Who has the authority to do that?
PRIEST:	It's my understanding that no one does.
HARRISON:	Okay. Who can exceed the 240 hours of respite?
PRIEST:	It's my understanding that no one.

(Ms. Priest testified that she is the official at DDSN who is responsible for the administration of the MR/RD Medicaid waiver program. Transcript at 7. Ms. Priest holds a bachelor's degree in Social Work, but she has no graduate or medical training.)

Ms. Lewis is the official at DHHS responsible for the administration of the MR/RD Medicaid Waiver program. She holds no graduate degree and has no medical training. Id. at 85. When asked about whether DDSN can authorize anyone to exceed the caps, the following exchange occurred:

HARRISON:	Have you approved their policy of allowing some people to get more services than the cap under the Waiver and not allowing other people to get those services?
LEWIS:	The cap—you mean the cap in the renewal?
HARRISON:	Uh-huh.
LEWIS:	The service caps. The service caps are the service caps as far as I'm aware the only people who are exceeding the caps are the people who are currently under appeal.

Transcript at 90.

The service coordinator, Ms. Auker, was the only one of Respondent's witness who had actually met A.M. or knew anything about his services. She also has no medical training. Ms. Auker likewise testified that the agency has established a binding norm and that she has no discretion to exceed the caps:

HARRISON:	Thank you, Mr. Hepfer. As service coordinator can you exceed the number, the 28 hours of PCA services if you feel like Al needs additional services?
AUKER:	PCA II hours, no.
HARRISON:	What about the—could you exceed the adult companion services if he needed those?
AUKER:	No.
HARRISON:	Okay, could you, could you provide additional—could you provide—could you authorize speech therapy now?
AUKER:	Under the new waiver, no.
HARRISON:	Could you authorize physical therapy?
AUKER:	Under the new provisions, no.

Transcript at 61.

In *Hickey,* Judge Durden discussed the agency's argument that the agency may enforce waiver amendments without promulgating regulations:

> I find no legal support for this argument. On the contrary, other states which have considered this precise question have held the provisions of a waiver document must be promulgated as regulation under the States' APA in order to be enforceable as a rule or binding norm.

Id. at 7. Citing *McCrann v. N.C. Dept. Of Health and Human Services,* 704 S.E.2d 899 (N.C. App. 2011). Also citing *Hoban v. State of Vermont,* Op. No. 200-4-05, Lexis 40 (Vt. Sup. 2005) and *Mullins v. N. Dakota Dept. of Human Services*, 454 N.W.2d 732 (N.D. 1990). Federal Courts have consistently held that States may not violate the Medicaid Act or the Americans with Disabilities Act by enforcing caps or reductions in services based on obtaining approval from a bureaucrat at the CMS Regional Office. *Peter B. v. Sanford,* No. 6:10-CV-00767, 2011 WL

824584 at *1 (D.S.C. March 7, 2011), *Pashby v. Cansler*, ___ F.R.D. ___, 2011 WL 6130819 at *6 (E.D. N.C. 2011). More recently, in *Moore v. Cook* the State was prohibited from reducing a severely disabled child's nursing services from 94 hours a week to 84 hours a week based on a binding norm establishing a cap on these services. No. 1:07-CV-631-TWT, 2012 WL 1380220, at *10 (N.D. *Ga.* June 19, 2012).

Respondent's reliance on *Jane Doe v. DHHS*, another case where Respondent has ignored the requirements of both state and federal law (federal case is *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007) and Case No. 10-1191 (4th Cir. March 24, 2011) is also misplaced. That decision, issued by the South Carolina Supreme Court, does not support Respondent's claim that waiver amendments not promulgated as regulations have the force and effect of law. The South Carolina Supreme Court held in *Jane Doe v. DHHS* that:

> 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.

398 S.C. 62, fn. 7, 727 S.E.2d 605 (S.C. 2011). Appellant requests that this Court order Respondent to comply with the South Carolina Administrative Law Court and Hickey and that Respondent be required to provide services that are deemed by A.M.'s treating physician to be medically necessary absent a clear showing that providing those services would fundamentally alter the State's sytem.

2. **Appellant's claim that Respondent violated the Medicaid Act and the Americans**

with Disabilities Act (ADA) by failing to provide services with reasonable promptness to prevent institutionalization is supported by substantial evidence in the Record.

Substantial evidence supports Appellant's claim that DHHS has denied medically necessary services in violation of the Medicaid Act and the Americans with Disabilities Act (ADA). "Substantial evidence" requires more than a mere scintilla of evidence. Lark v. *Bi-Lo, Inc. 276* S.C. 130, 135 (S.C. 1981). Evidence must not be "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." *Palmetto Alliance, Inc. v. South Carolina Public Service Com'n,* 319 S.E.2d 695, 282 S.C. 430 (S.C. 1984). In this case, the Respondent failed to provide any evidence from a qualified medical source in support of its arbitrary determination that the services ordered by Myers physician are not medically necessary.

None of Respondent's witnesses were qualified to make medical treatment determinations. Ms. Auker testified that she considered the medical records of A.M.'s treating physician, but she was unable to point to any record supporting Respondent's contention that the services requested were not medically necessary:

HARRISON: Okay, tell me—read the part of the physician's records that outlaid this order.

AUKER: Which outlaid, I'm sorry?

HARRISON: That, that carried more weight than this order saying that this is how many hours he needs.

AUKER: There was nothing particular that weighed more than anything else. With talking with his mother, with talking with day program staff, with talking with—with looking at medical records, looking at everything together, there was no, no increase in medical needs. Nothing had changed

medically with him. He was not receiving nursing before. No medical needs had changed so there was no need to add nursing.

...

HARRISON: Did he need to be fed in the afternoon?

AUKER: Yes.

HARRISON: Did he need to fed in the evening?

AUKER: Yes.

HARRISON: Okay. And did the doctor say that he needed nursing services for those two feedings?

AUKER: Yes.

HARRISON: So, please show me the medical records that you considered to—that you gave deference to instead of this letter.

AUKER: I didn't give deference to anything. Not only can a nurse provide that but family members can provide the tube feedings.

HARRISON: But, but is a family obligated to do that?

AUKER: They're not obligated, no.

...

SCHINDLER: All right. We'll go off the record for a moment. Back on the record. I just received a copy of Mr. Myers medical record from Dr. Munn and I'm going to call this Respondent's Exhibit 7.

HARRISON: Okay, these are the medical records you relied upon?

AUKER: Yes.

SCHINDLER: Excuse me. Ms. Harrison, I actually misspoke. I'm calling this Petitioner's Exhibit 7. Please proceed. I'm sorry about that interruption.

HARRISON: Okay. Would you list each factor you relied upon in making the decision that he didn't need those nursing hours?

AUKER: Without looking directly, I mean usually what we do if I can just speak from what we usually do is we gather information, looking at all of the information, talking with Ms. Myers, talking with the parent, medical information and look at that information and what we—what we gather through the year for the person.

HARRISON: Okay, so talking to Ms. Myers she was telling you she needed those hours, was she not?

AUKER: Yes.

HARRISON: Okay, what did she say that you relied on to make that decision?

AUKER: I can't remember directly what she said to make the decision.

HARRISON: Okay, and isn't it true that you relied on her to provide the nursing services that were ordered by the physician?

AUKER: (Unclear) yes.

HARRISON: Okay, and how did you determine that this need would be met without providing nursing services?

AUKER: With the parent.

HARRISON: Okay, but the parent was saying she needed them.

AUKER: Right.

HARRISON: Okay, and the medical records show that he had a history of aspiration and pneumonia, is that correct?

AUKER: Yes.

HARRISON: Okay, and the medical records show that he had a history of a pressure sore?

AUKER: Yes.

HARRISON: Okay. Is there anywhere in the medical record that it says that he doesn't need the number of hours that were requested for tube feeding?

AUKER: No.

HARRISON: Okay. What would happen to Al absent Ms. Myers providing the tube feeding? If she didn't do that nursing service, if she said I'm not a nurse, I'm not going to do that? What would happen to Al if he stayed at home?

AUKER: If she wouldn't do the tube feeding at all then I guess institution, being placed in an institution.

HARRISON: What if he refused to go to an institution, what would happen to him?

AUKER: I don't know.

HARRISON: Would it affect his health if he didn't get the tube feeding?

AUKER: Of course.

Transcript at 69-71. This testimony proves that Respondent has ignored the mandates of *Olmstead v. L.C.*. *Olmstead v. L.C.*, 527 U.S. 581, 610 (1999). In that case, Justice Kennedy held States must give the treating physician the "greatest of deference" in making treatment decisions:

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

Id. at 610. The Fourth Circuit has addressed the role the treating physician must play in ERISA

litigation. In *Frankton v. Metropolitan Life Ins.* Co., the Fourth Circuit held that although the "treating physician's rule" is not applicable in ERISA lawsuits, plan administrators are still prohibited from ignoring "reliable evidence" from a treating source. 09-2184 (4th Cir. May 23, 2011). In *Frankton,* unlike this case, the corporation hired "an independent medical examiner and an independent physician consultant to review Frankton's entire claim file" Id. at There is nothing in the record to document that Respondent's medical director, or any qualified source, reviewed A.M.'s "entire claim file." There is no evidence that any physician hired by the Respondent reviewed any of A.M.'s medical records. Unlike the case in *Frankton*, Defendants'medical expert did not reach "reasoned and principled conclusions" or prepare detailed reports. More than two years after the reductions were announced, Respondent has never produced evidence from a treating, or even an examining source to determine that the services his treating physician ordered are not medically necessary. In *Elliott v. Sara Lee Corp.,*the Fourth Circuit held that the treating physician would be applicable when "an award of benefits [is] based on a treating doctor's opinion of disability absent persuasive contradictory evidence." 190 F.3d 601, 607-08 (4th Cir. 1999).

A State may place limitations on services based on reasonable standards for determining medical necessity. But here, as in *Moore v. Cook,* the State's placement determinations have been based on "bureaucratic gobbledegook having no relation to her actual condition or needs." 2012 WL 1380220, at *10 (N.D. *Ga.* Apr. 20, 2012). A.M.'s physician determined what services were necessary for him to remain in the least restrictive setting, at home with his family. Plaintiff's Exhibits 4, 5, 6 and 7. While the DDSN service coordinator claimed to have considered his opinion in determining that A.M., coincidentally, needs only those services provided under the waiver amendments,

A.M.'s physician determined that an assistive communications device is necessary to meet his medical needs and his witnesses presented credible testimony at the hearing that funding

for this device has not been provided with reasonable promptness. Ms. Ray, who holds a master's degree in speech and language therapy testified at length about his need for the device. Transcript at 105, 107, 108, 109, 116. His psychological services provider also testified about his need for the device. Transcript at 120, 121, 134. His service coordinator testified that the device was never authorized, but none of the Respondent's witnesses presented evidence to contradict his physician's order that the device was medically necessary:

> HEPFER: Okay. And did Mr. Myers ever use his speech therapy authorization, do you know?
>
> AUKER: We had never authorized it. We had talked about it several times. I know the last time I had talked with Ms. Myers she was working with Lennie Mullis because Lennie knew somebody that could possibly get the kind of device Ms. Myers was looking for. Ms. Myers—they kind of knew what kind of device they were looking for and so she said that Ms. Mullis was helping with her to—I think they had already located a person but they were looking at a certain kind of device.

The reasonable promptness mandate of the Medicaid Act required that the device be provided within 90 days. *Doe v. Kidd I and II, supra.*

The Respondent's decision to deny services ordered by A.M.'s physician, physical therapist and psychological service provider are not supported by substantial evidence and the decision of the hearing officer should be reversed. Appellant requests that all medically necessary services contained in the plan of care in effect upon entry to the nursing home be provided within 30 days and that services be offered to provide A.M. an opportunity to return to the community.

3. **Appellant's issues of retaliation and prohibited ex parte communications were not waived and there is substantial evidence to support those claims.**

This Court's determination that Appellant's objection to the ex parte communication between DDSN and the Office of Appeals and Hearings should be reversed. The prior order of this Court remanded the case to the HHS Office of Appeals and Hearings for an evidentiary hearing on the merits. It was not an appealable order. Appellant complained of due process

violations in his brief in the first appeal to the Administrative Law Court. Pages 6, 14, 16, 20, 23, 25. On page 25 of the "consolidated brief," Appellant complained of improper ex parte communications between Jacob Chourey and the Director of the DHHS Office of Appeals and Hearings. (Brief refers to ex parte memos contained in Myers Record on Appeal at 42 and 44.) A.M. complained that:

> The tribunal not only participated in ex parte communications with the agencies, but it is apparent from the record that there was a bias against the disabled persons who brought these appeals from the beginning of the process. The hearing officers ignored Appellants' requests for orders requiring the agencies to provide documents and requesting depositions. Indeed, their appeals were dismissed by DHHS hearing officers, despite mandatory language in the Medicaid Act requiring an evidentiary hearing.

The next document in the record is an ex parte memo from Jacob Chorey to Mr. Crouch. Myers R. at 44. Mr. Chorey informed Mr. Crouch in this ex parte memo how many hours that Al was receiving and he discussed the changes under the new waiver. Id. Mr. Chorey then sent another ex parte memo, on February 24, 2010, to Mr. Crouch providing him with more ex parte discussion about the services Al was receiving and discussing the changes to the waiver. Myers R. At 42. Mr. Chorey informed Mr. Crouch in this ex parte memo that CMS had approved these changes. The very next day after this second ex parte communication, hearing officer Janet Goode sent Al's guardian an Interlocutory Order discussing Dr. Buscemi's letter and the ex parte correspondence from Mr. Chorey (which was not provided to Appellant). In this Order, she requires Al's guardian by March 18, 2010 to "submit an error by the Agency that these services were being received prior to the renewal of the Waiver and are now terminated." Myers R. at 41.

Whether the decision to deny services necessary to comply with A.M.'s doctor's orders was based on ex parte communications was an issue going to the merits of his claim. It was error to determine that this issue was waived prior to giving A.M. an opportunity to present evidence at a fair hearing. The record contains evidence of ex parte communications with DDSN employees about each waiver participant whose case was consolidated, followed by the hearing officer dismissing their appeals in blatant violation of 42 U.S.C. 1396a(a)(3) and fair hearing

regulations, which require that the decision be based entirely on evidence presented at the hearing. 42 C.F.R. 431.244(a).

In *Mullis v. DHHS*, this Court condemned DHHS and DDSN for ex parte communications which resulted in the Office on Appeals and Hearings issuing an arbitrary order which violated the rights of a witness in this case. 10-08-0775, April 23, 2012 at 14. A.M. did not waive his right to complain of his due process rights being violated by the agency working secretly with the hearing office to obtain the result the agencies wanted.

As in *Mullis*, Appellant has presented substantial evidence that the decision of the agency was arbitrary and retaliatory. Federal Regulations require a final determination within 90 days. 42 C.F.R. 431.244(f)(1). In *Shakhnes v. Eggleston,* the federal district court held that "Thus the regulation demands that " final administrative action" be taken " ordinarily, within 90 days" after a request for a fair hearing, and in some circumstances justifying expedited resolution that it be taken " not later than 3 working days after" receipt of the individual's file or her request for a fair hearing. *Id.* 740 F.Supp.2d 602 (S.D.N.Y. 2010). In *Doe v. Kidd,* the Fourth Circuit held that "reasonable promptness" requires action within 45 or 90 days. *Doe v. Kidd II* (2011) at fn 2.[1]

There is no explanation other than retaliation to explain why the agency witnesses have admitted that A.M. continues to need physical therapy, psychological services, dental care, speech and an augmentative communications device, but funding for these services has been denied. DDSN determined on its PASARR evaluation that once Al was institutionalized, he needed no "specialized services" which are not covered by "regular" nursing home services. Respondent's claim of "surprise" cannot be justified, first because any delay in granting A.M. a hearing is purely the fault of the agencies and secondly because neither the federal regulations

---

[1] Respondent also ignores the holding of the United States Court of Appeals in *Doe v. Kidd.* I and II, supra. In those cases, the Court of Appeals instructed Respondent that it may not substitute respite services for a more expensive waiver service (in that case, residential habilitation).

nor the state regulations require Appellant to provide notice of his strategy or his arguments before the hearing. It is ironic that the agency that had a clear obligation to provide the reasons for the denial and the statutes relied upon shouts prejudice when its reasons presented at the hearing (i.e. change in definition of services, overuse of services, etc.) were totally unrelated to the reasons provided on the defective notice provided to A.M.

4. Respondent attempts in its brief to cure the hearing officer's failure to conduct an analysis of Appellant's claim that the State has violated the ADA.

In its brief, Respondent reviews the analysis for compliance with the Americans with Disabilities Act (ADA). Page 10. This analysis cannot cure the hearing officer's failure to apply the law to the facts of this case. The burden is on the State to prove that providing the services that are medically necessary to prevent the risk of institutionalization would fundamentally alter the States' programs. The hearing officer's decision that Respondent did not violate the ADA is not supported by substantial evidence in the record and Appellant has provided convincing evidence, including actually being admitted to an institution, that the State has failed to comply with the integration mandate of the ADA.

5. Respondent's claim of "surprise" is not justified because Appellant had not duty to inform the State of his arguments to be presented at the evidentiary hearing and any delay was the fault of the State..

The obligation to provide notice is a one way street in fair hearings. 42 C.F.R. 431.2 There is no corresponding requirement placed on Medicaid participants to inform the State of what its arguments will be or the evidence it will submit. Federal regulations specifically require the State to provide a written notice that contains the reasons for the denial or reductions and the statute relied upon. 42 C.F.R. 431.210. Respondents' witnesses admitted that such notice was never provided.

There is no requirement in state regulations that a Medicaid participant provide notice of the evidence to be presented in his or her appeal. Those regulations do require a provider to include specific information about the disallowances in question, the nature of the issues and the

jurisdictional basis of the claim State regulations contained at § 126-152, titled "Appeal Procedure" provide that:

> A. An appeal shall be initiated by the filing of a notice of appeal within thirty (30) days of written notice of the Agency action or decision which forms the basis of the appeal. The failure to file the requisite notice of appeal within the thirty (30) day period specified above shall render the Agency action or decision final; provided, that should the written notice specify some period to appeal other than thirty (30) days, that period shall apply; provided, that the requirement that written notice be given by the Agency shall not be applicable to situations where applicants for Medicaid benefits acquire the right to appeal when the Agency fails to act on the application within the time period specified by federal regulation.
>
> B. The notice of appeal shall be in writing and shall be directed to Appeals and Hearings, Department of Health and Human Services, Post Office Box 8206, Columbia, South Carolina 29202-8206. In appeals by providers, the notice of appeal shall state with specificity the adjustment(s) or disallowance(s) in question, the nature of the Issue(s) in contest, the jurisdictional basis of the appeal and the legal authority upon which the appellant relies.
>
> C. If a notice of appeal does not satisfy the requirements of paragraph (B) above, the Hearing Officer, upon his own motion or by motion by an adverse party, may require a more definite and certain statement.

Respondent knew full well that the PASSAR evaluation had been conducted by its agent, an employee of DDSN, with no review of Appellant's medical records, without his doctor, or even his service coordinator being contacted to determine his needs for specialized services. There is no justifiable ground in the record to terminate funding for these services. The decision to terminate funding for physical therapy, speech (including an assistive communications device), dental care and psychological services was properly presented to the hearing officer.

Respectfully submitted,

Patricia L. Harrison
611 Holly Street
Columbia, South Carolina 29205
(803) 256 2017
Attorney for A.M.

September 27, 2012

THE STATE OF SOUTH CAROLINA

IN THE COURT OF APPEALS

APPEAL FROM THE SOUTH CAROLINA ADMINISTRATIVE LAW COURT

Honorable Shirley C. Robinson

Docket No.: 12-ALJ-08-0173-AP

Albert C. Myers,
Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent.

RECEIVED
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SC Court of Appeals

NOTICE OF APPEAL

Carolyn Myers, guardian for Albert C. Myers, appeals the order of Honorable Shirley C. Robinson dated and filed February 3, 2014 in Richland County, South Carolina.

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

Respondent's Counsel of Record:

Office of General Counsel
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, South Carolina 29202-8206

March 5, 2014

IN THE ADMINISTRATIVE COURT OF APPEALS

Appeal of the Decision of Administrative Law Judge Shirley C. Robinson

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RECEIVED
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SC Court of Appeals

Albert C. Myers,
Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent

Docket No. 12-ALJ-08-0173-AP

CERTIFICATE OF SERVICE

I certify that I have served the Notice of Appeal on the Office of General Counsel, South Carolina Department of Health and Human Services by hand delivery at a hearing held at the South Carolina Administrative Law Court on March 5, 2014 and filed the same with the South Carolina Administrative Law Court by hand delivery on March 5, 2014.

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

Columbia, South Carolina
March 5, 2014

SCHINDLER: We are on the record. This is an administrative appeal brought by Patricia Harrison on behalf of Albert Cooper Myers. The present date is January 6, 2012. My name is Betsy Schindler and I will be the presiding officer in this matter. I will conduct this hearing in accordance with the South Carolina Administrative Procedures Act and the Department of Health and Human Services Regulations 126.150 through 126.158 which are regulations on appeals and hearings. I will not make decision today. When I make my decision, both parties will be notified in writing. During the hearing, each party has the following rights: the right to ask questions, the right to call witnesses and present documents, the right to cross-examine witnesses and examine documents of the other party, and the right to refute testimony of the other party. The Petitioner today is Albert Myers who is represented by Patricia Harrison. The Respondent is the South Carolina Department of Health and Human Services who is represented by Richard Hepfer. Also in attendance today for the Petitioner we have Sandra Ray and what is GAL in...

RAY: I was the Guar—I am the Guardian Ad Litem in a Probate action.

SCHINDLER: All right. Juanita Aukner.

AUKER: Auker. I signed it in the wrong place.

SCHINDLER: Okay, so who are you with?

AUKER: DDSN.

SCHINDLER: So you're with the Respondent?

AUKER: Yes.

SCHINDLER: Okay, thank you. And what do you do with DDSN? You're with Kershaw County Board?

AUKER: Kershaw County Board of Disabilities. I'm a Service Coordinator.

SCHINDLER: Thank you. Carolyn Myers who is the mother of Mr. Albert Myers. Daniel (Unclear). I apologize for my pronunciation, who is with South Carolina Legal Associates, is that right?

VOICE: Legal Services.

SCHINDLER: Legal Services and is a observer, okay. For the Respondent, the spokesperson is Richard Hepfer. Juanita Auker...

AUKER: Auker.

SCHINDLER: Oh Auker, okay, you signed both places.

AUKER: Yes, I'm sorry.

SCHINDLER: Okay. I'm easily confused. Okay, here we go. Janet Priest who's with South Carolina Disabilities and Special Needs. Theo Warren...

WARREN: Thoyd.

SCHINDLER: Thoyd. And what's your last name?

WARREN: Warren.

SCHINDLER: Warren, okay, Thoyd Warren who is the Executive Director of the Kershaw County Disabilities and Special Needs Board. Kara Lewis who's with Health and Human Services in CLTC area, Community Long Term Care. Observing the hearing we have Shealy Ribault who is an Assistant General Counsel with Health and Human Services. Robert French who is the Director of Appeals and Hearings. Eric Martin who is a contract hearing officer with Appeals and Hearings. Nancy Law with the Office of Patricia Harrison. And Lisa Jones who is a personal friend of Mr. Myers, is that correct?

JONES: Yes.

SCHINDLER: Okay, have I listed everybody? Okay. The issue involved in this case today is whether the decision of the South Carolina Department of Health and Human Services and its' agent, the Department of Disabilities and Special Needs was correct in reducing or eliminating certain mental retardation related disability Waiver services, specifically reduction of personal care aide II, daily 24 hour respite services and the elimination of physical therapy, occupational therapy, speech therapy, and coverage of augmented communications evaluation and equipment. Mr. Hepfer, is that the issue as you understand it?

HEPFER: Basically I would characterize it as a reconfiguration of services rather than a reduction of services.

SCHINDLER: All right, thank you. Ms. Harrison?

HARRISON: The issue is about the reduction of DDSN services including PT, OT, and augmented device and that they are to provide services with reasonable promptness.

SCHINDLER: All right, thank you. All right, I'm going to take official notice of the file for the record as soon as I find it. All right, Petitioner's Exhibit Number 1 is a four-page packet including a letter dated 12/9/2011 from Ms. Harrison and an Order on Motion to Alter or Amend the Motion so that was dated December 6, 2011; Petitioner's Exhibit 2 is a package, a large package of documents including CFR references, Medicaid Policy Manual, and other documents; Petitioner's Exhibit 3 appears to be copies of the State Plan and DDSN records; Petitioner's Exhibit 4 is Dr. Munn's letter; Petitioner Exhibit 5 is Dr. Galloway Coker's letter; and Petitioner's Exhibit 6 is Dr. Munn's affidavit. Mr. Hepfer, I should have asked you before I listed all these, the package of CFR references, the DDSN records and the letters from the doctors and affidavit, do you have any objection to these being admitted to the record?

HEPFER: I don't have any objection to them being admitted, Madam Hearing Officer. I would note that the affidavits and letters are hearsay and unless the people are provided for cross-examination but I don't have any problem for them being admitted for whatever probative value you can find.

SCHINDLER: Thank you. Respondent's Exhibit 1 is a package including letter dated 12/14/11 from Mr. Hepfer and an ALC order dated July 19, 2011, that's thirteen pages in total; Respondent's Exhibit 2 is a pre-hearing brief which is twelve pages including a cover letter; Respondent's Exhibits 3 and 4 are case law. Ms. Harrison, do you have any objection to the case law being admitted to the record?

HARRISON: We don't have an objection, no. I would, I would respond to Mr. Hepfer's issue about the hearsay. We have addressed this issue in the past and the Agency has accepted statements signed by physicians, health care

providers, and they have not been treated as hearsay so if they have changed their policy about that we would ask that we be allowed to continue the hearing at the end and allow us to bring those people in. People can't afford to have doctors sit around all day. So that has been the practice for many years that doctor's statements that, that healthcare professional statements have been admitted in writing so if that policy has changed and I find out about it at the hearing, we would ask that we be allowed to take additional testimony from those individuals.

HEPFER: Madam Hearing Officer, I can't make non-hearsay something which obviously is hearsay. The—and all—in my memory, I've made the similar objection or similar statements, it's not really an objection. It's just a statement pointing out the obvious character of the documents submitted and as I said I have no objection to them being admitted but, but I do want to note that they are hearsay, that the person is not here for cross-examination and you can assign whatever probative value you want to them.

SCHINDLER: Thank you. Well, I'm going to admit them to the record. Hearsay is admissible in administrative hearings so. All right, in addition Hearing Officer Exhibit 1 is the Administrative Law Court Order of November 9, 2011, that was sixteen pages. And this is Appeal Case Number 11-MISC-302 that all those exhibits pertain to. Now is the time for opening statements. Mr. Hepfer, would you like to make an opening statement?

HEPFER: Just very briefly, Madam Hearing Officer. Mr. Myers is a intellectually developmentally disabled individual who with the help and supervision of his mom has been living in the community. In January of 2010, the Department renewed the MR/RD Waiver and that renewal included some limitation on services and it eliminated others services. The Waiver limitations affected Mr. Myers in partially in some of these ways. The Personal Care Aide II services, that's hands-on help, bathing, feeding, dressing, toileting were limited. Respite care was also limited but with certain provisions to allow additional respite hours to be provided. PT,

physical therapy, occupational therapy and speech therapy were eliminated in the Waiver. For adults there is an alternative way to secure those services and I detail that in my hearing brief to which I refer. We believe and hope to show that these changes themselves did not materially impact the Petitioner's ability to be maintained in the community because as we will hope to show, the current packages of services within the new Waiver are sufficient to do so. Thank you.

SCHINDLER: Thank you. Ms. Harrison?

HARRISON: Thank you, Your Honor. This is a consolidated case. It was consolidated by the Administrative Law Judge with warranted individuals. Al Myers is one of those individuals. Chuck B., Michelle M., and Susan E. The issue in this case is whether services have been provided in sufficient amount, scope and duration. Whether they've been provided with reasonable promptness and whether choices have been provided of providers have been provided. We will show contrary to Mr. Hepfer's, with all due respect to Mr. Hepfer, that these changes did materially impact Al Myers because as a result of the changes and the lack of certainty about what will be provided and won't be provided, Al Myers is now in a nursing home. The driving—the most important issue we have here, we have violations of the Medicaid Act including the PASRR Requirements but we also—I would ask that the court keep its' focus on Olmstead versus LC in which the United States Supreme Court required States to make treatment decisions based on giving the greatest of deference to the treating physician and what we have in this case is tremendous medical needs that are being ignored by the Agency and we will show that the Agency has violated not only the Medicaid Act and the Nursing Home Reform Act but also the Americans with Disabilities Act, and the clear requirements under Olmstead to make treatment decisions based on qualified medical personnel, not on bureaucrats who are reducing services solely for the reason of saving money.

SCHINDLER: Thank you.

HEPFER: Call—go ahead.

SCHINDLER: What I'm going to do now is swear in all the witnesses that are going to testify today. This is a quasi-judicial hearing so your testimony will be sworn. What I'll ask you to do is to raise your right hand and I'll read the oath and then you'll affirm and state your name for the record. I'm going to go around and swear in everybody who might testify today. And what I'm going to do is start on this side of the room and move all the way around. Please raise your right hands. Do you swear or affirm that the testimony you are about to give is the truth?

PRIEST: State my name?

SCHINDLER: Yes.

PRIEST: Janet Priest and I do.

AUKER: Juanita Auker, I do.

HEPFER: I don't plan to call Ms. Lewis as a witness.

SCHINDLER: All right.

RAY: Sandra Ray, I do.

MYERS: Carolyn Myers, I may.

HARRISON: She may testify but you will tell the truth.

RAY: Oh yes, I will tell the truth.

SCHINDLER: Thank you.

HARRISON: And Ms. Schindler, we do have one other witness that has another obligation that will be here before...

SCHINDLER: Okay.

HARRISON: ...we call her.

SCHINDLER: Well, we'll swear them in when they arrive. All right, well, we're ready to begin testimonies so Mr. Hepfer?

HEPFER: Janet Priest. Ms. Priest, would you please identify yourself for the Hearing Officer and for the people here.

PRIEST: My name is Janet Priest and I work for the Department of Disabilities and Special Needs.

HEPFER: Okay, and what's your—what are your duties in that capacity?

PRIEST: I'm the Division Director for the Intellectual Disabilities Division of DDSN. As part of that I'm responsible for day residential and two of DDSN's waivers.

HEPFER: Okay, and would those be—would one of those be the MR/RD Waiver, what I refer to as the MR/RD Waiver?

PRIEST: Yes.

HEPFER: Which is the Federal designation for the Waiver. What is your education?

PRIEST: I have a Bachelor's Degree in Social Work from Winthrop.

HEPFER: Okay, and...

PRIEST: And have worked for DDSN for twenty years and prior to that I worked for (Unclear).

HEPFER: Okay, thank you. The January 1, 2010 Waiver Renewal limited some services and eliminated others, is that correct?

PRIEST: That's correct.

HEPFER: Okay. And can you tell us what some of the limitations were that affected Mr. Myers.

PRIEST: As I understand the issue, one of the major issues is the limitation on personal care. Other issues are related to the therapies.

HEPFER: Okay. So Personal Care Aide II and I were limited how?

PRIEST: Prior to the Waiver Renewal there were no defined limits on the services. The limits were based on identified need, assessed need, and those needs assessed by the person's service coordinator. What the changes did was in effect put in a maximum amount of service or number of hours that could be authorized by a service coordinator.

HEPFER: Was that both for PCA I and PCA II, Personal Care Aide I and Personal Care Aide II?

PRIEST: There were two different service limits entered. One was for Personal Care, one was for Personal Care II.

HEPFER: Okay, and what about Respite Services, was that also a service that impacted Mr. Myers.

PRIEST: As I understand it, yes.

HEPFER: Okay, and how was that limited?

PRIEST: Respite Services were as I recall, service limits were entered into the Waiver at the time of the renewal. We used to have what was termed a daily rate for respite. The daily rate was removed in favor of hourly respite meaning that instead of considering an amount of time a day we counted every hour that was provided during that day. And then there were limitations placed on respite.

HEPFER: What about physical therapy, occupational therapy and speech therapy?

PRIEST: Those definitions, service definitions were removed from the Waiver because they were covered by the State Plan.

HEPFER: Okay. All right. I'm going to ask you to look at a couple of documents and ask you to identify them.

PRIEST: This seems to be the MR Waiver.

HEPFER: Okay, that was the renewed document that was renewed January 1, 2010?

PRIEST: It appears to be.

HEPFER: Okay. All right, and you have a copy of this, right?

HARRISON: Uh-huh.

HEPFER: I'd like to admit this please. It's Respondent's Exhibit whatever.

SCHINDLER: We've already lost count. Ms. Harrison, do you have any objection to this put in the record?

HARRISON: I have no objection.

SCHINDLER: I got to find my list so I can see what—this is going to be Respondent's Exhibit 5.

HEPFER: All right. And I have another two documents for you to take a look at and identify for the Hearing Officer and for the other people here. I'm going to hand you two other documents and would you identify them, please?

PRIEST: The first one is the—appears to be a chapter from the MR/RD Waiver Manual for Service Coordinators.

HEPFER: And that manual is something that is issued by the Department of Disabilities and Special Needs, right?

PRIEST: Correct.

HEPFER: Okay, thank you.

PRIEST: The second one appears to be the Scope of Services for Personal Care which is issued by the Department of Health and Human Services.

HEPFER: Okay, thank you. I'd like to—Madam Hearing Officer, I'd like to admit those Exhibits as 6 and 7, I guess.

SCHINDLER: And does Ms. Harrison already have these?

HEPFER: I believe so.

HARRISON: I do have those.

SCHINDLER: Okay. Do you have any objection to these?

HARRISON: I don't have any objection.

SCHINDLER: These will be Respondent's Exhibit 6 will be the chapter from the Waiver Manual. It looks like it's—okay, thank you, and then Respondent's 7 will be the Scope of Services for PC Care.

HEPFER: Okay, and I have one other document to hand Ms. Priest and ask her to identify that.

PRIEST: This appears to be the Waiver Manual chapter for Respite.

HEPFER: Okay, I'd like to admit that as Respondent's Exhibit 8 and I believe I provided Ms. Harrison a copy already.

SCHINDLER: And I will call this Respondent's 8. Thank you, Mr. Hepfer.

HEPFER: Okay. Now what do you remember about the reasons for changing PCA or for limiting PCA services?

PRIEST: It's been several years ago. As I recall, we understood in our frequent conversations with the Department of Health and Human Services that the same service, Personal Care II, as provided through the Elderly and Disabled Waiver was authorized for people who needed it at a very different rate than was typically authorized for people with intellectual disabilities because the service is hands-on care to a person. The intellectual disability part really would not impact the amount of care, typically impact the amount of care that would be needed especially when you consider that the service does not include supervision of the person. It is defined as active hands-on care, supervision is not part of the service

itself. So if the service is defined as active hands-on care and does not include routine supervision that is needed, then the service is intended for a bath to be given, a meal to be provided, a meal to be cooked, a bed to be made, a floor to be swept, and that is the service. Having said that, when we looked at the services that had been authorized for people with disabilities we often saw multiple, multiple hours of care authorized. Most people could not tolerate being bathed, groomed, dressed, fed for that many consecutive hours. It was the impression if supervision is not part of the service and it is not, that there was a misunderstanding of the service definition. Additionally we learned from Health and Human Services that those people in the Elderly and Disabled Waiver who receive the service most typically were authorized to receive ten hours per week of service. That was typical. In more extreme situations, the typical authorization was 25 hours a week. It was rare, almost unheard of in the Elderly and Disabled Waiver population of people for CLTC to ever authorize in excess of 25 hours a week.

HEPFER: Explain what CLTC is.

PRIEST: Community Long Term Care and they were the operators and administrators of the then Elderly and Disabled and now the Community Choices I think is the correct term waiver. So understanding that with all of the years of experience with the Elderly and Disabled Waiver and understanding that we frequently heard from families that they wanted to move away from the Elderly and Disabled Waiver because they were limited to 25 hours a week of personal care. We realized that something needed to be done to clarify what was meant by personal care in the MR Waiver so there were changes to the definition that were made and the changes included words like active hands-on care because that is the intent of the service. It is active hands-on care. It does not include supervision, it never has. So if you are providing active hands-on care, if you look at the number of hours that most people would benefit from active hands-on care and you think through what people do during a day to actively care

for themselves and their bodies, the thought was 25 hours as was the higher end of authorization usually provided by CLTC was probably not enough. It really did not translate over seven days. If you can't bathe then you can't bathe Monday, Saturday, Sunday, any day of the week so we stretched it to seven days and four hours a day so that was the thought process. That was not—that was the thought processes that were behind the limitations. But the service again is active hands-on care. It does not include supervision. It does not include waiting for a task to be needed, meaning if you have someone that is incontinent, it is not waiting for the diaper to need to be changed. It is changing it while you're there and while during the provision of the service. So it is walking in, giving the bath, washing the hair, doing the grooming, changing the diaper if it's needed, cleaning the floor, cooking a meal and that is the end of the service. Supervision is not intended to be part of it.

HEPFER: What about PCA I services, Personal Care Aid I services? What's the difference between Personal Care Aide I and II?

PRIEST: Personal Care I is specifically not hands-on care to the person per se'. As I understand Personal Care I, Personal Care I is more of a housekeeping or homemaker kind of service so Personal Care I hours are available. If you have extensive needs with personal grooming that would be PC II. If the 28 hours is not enough because of perhaps contractures or other difficulties that someone may have in completing personal care, then PC I services are there to clean the person's—to provide housekeeping or homemaker kinds of services to the person's area. So again, the point is not with per—with PC I, the point is not to clean the whole house, cut the yard, clean out the gutters but instead the point with personal care is to keep the person's area, the area that they use clean and tidy.

HEPFER: I've heard the term activities of daily living and instrumental activities of daily living. Are you familiar with those terms?

PRIEST: I have heard them and I have to look them up and use a standard definition before I write them. It's not something that I carry around.

HEPFER: Okay. Would it be fair to say that PCA I was—or do you know if it's fair to say that PCA I is designed to deal with instrumental activities of daily living and PCA II is designed to deal with actual activities of daily living such as bathing, dressing, feeding, toileting?

PRIEST: That is my understanding. Although it is also my understanding that you may utilize a PC II to do some IADL's as well.

HEPFER: Okay. Well, how does respite care fit in with all this then?

PRIEST: Respite by definition is care provided in the absence of the caregiver or the need of relief of the caregiver. So by definition, respite includes any care that by law could be performed and it is the care that the caregiver would typically do so if as a family member or as a parent you would typically help somebody eat lunch, sit and play a game with them in the afternoon, whatever the caregiver would typically do is considered respite.

HEPFER: And respite care is limited in the waiver to some degree, isn't that correct?

PRIEST: It is.

HEPFER: In the new waiver.

PRIEST: It is.

HEPFER: Okay. How is it limited, do you know?

PRIEST: As I recall and without looking at it there is a limit of 68 hours a month but there is an exception process whereby additional hours of service can be authorized.

HEPFER: Okay, so up to how many hours, do you know, could the exception...

PRIEST: I have not looked at it in a long time and I don't—I'd be—I can look in the waiver document of the manual thing.

HEPFER: Well, how about the manual? Let's look at the manual. That's Exhibit, I forget, 7?

SCHINDLER: 8.

HEPFER: 8, sorry.

SCHINDLER: That's all right.

HEPFER: So how many from looking at the manual and refreshing your memory from the manual what do you—what is allowed in terms of respite?

PRIEST: And exception of up to 240 units which would be 240 hours may be authorized.

HEPFER: Okay, and what are the criteria for authorizing those exceptions?

PRIEST: They may be authorized when the caregiver is hospitalized or in need of medical treatment, the participant's need for constant hands-on direct care and supervision due to complex medical condition or severity of disability or the seasonal relief for those over 12 who attend school and whose parents work where care is needed during the summer, the summer break from school.

HEPFER: Okay, and that's—you're reading from the manual, right?

PRIEST: Yes.

HEPFER: Okay, thank you. So when you—when you I guess you divide it out you divide 4.3, the usual number of weeks in a month is the 4.3 if you take the whole year, so you'd divide by 4.3 into 68 to get the weekly number, is that, is that approximately correct?

PRIEST: Roughly, yes.

HEPFER: Okay. Okay. So it could be whatever 4.3 is into 68 up to whatever 4.3 is into 240, right?

PRIEST: Correct.

HEPFER: Per week. Okay, all right, and again respite being characterized, do I understand you as more supervisory rather than supervisory in terms of what the normal caregiver would offer to the individual?

PRIEST: Supervision is definitely part of respite. It's whatever care the caregiver would normally provide. Many people with intellectual disabilities need supervision and that is a large part of the care that's typically provided so that is available through respite.

HEPFER: And how do individuals who care for developmentally disabled people, how do they get respite services? What's the mechanism for getting respite services?

PRIEST: There would be an assessed need and a service coordinator would authorize the service.

HEPFER: And where would they get the actual provider?

PRIEST: They would choose the provider from available providers.

HEPFER: And where would they get a list or...

PRIEST: From the service coordinator.

HEPFER: Okay. And where would the service coordinator get that list of available providers?

PRIEST: There's a provider list that's available on the DDSN website.

HEPFER: Okay. And are those—are those people employed by agencies that also provide...

PRIEST: The provider—the provider list is a list of agencies that provide respite.

HEPFER: Okay, all right. And if a person wanted to engage an individual to provide respite services, would they be able to just employ the individual?

PRIEST: Meaning the family?

HEPFER: Yeah.

PRIEST: In the Waiver document there are provider qualifications that are listed and in addition to the provider qualifications, it lists kinds of providers that are available, so as I recall in the Waiver document, the providers of respite are an ICFMR, a nursing facility, and these are the types of agencies that can bill Medicaid, an ICF—for respite, an ICFMR, a nursing facility, a community residential care facility, DDSN and Medicaid enrolled respite care providers.

HEPFER: And those Medicaid enrolled respite care providers, would they provide services in the home? Or could they?

PRIEST: All respite care is provided typically in the home.

HEPFER: Except for institutional respite...

PRIEST: Except for institutional, correct.

HEPFER: ...these that you listed in nursing homes and so forth.

PRIEST: Correct.

HEPFER: And for the individual who's providing respite care, how do those people get paid I guess?

PRIEST: If an individual wants to provide respite, they can be employed by an agency.

HEPFER: Oh, an agency being like a Nightingale or Care Pro that provides personal care aide services also, right?

PRIEST: Right, or a qualified provider. DDSN is the provider of respite that bills Medicaid but DDSN also subcontracts with DSN Boards and there is a process for qualified providers for providers to become qualified in order to contract with DDSN to provide respite.

HEPFER: So where would the respite care provider be employed, I guess that's my question.

PRIEST: Are you talking about the respite care giver?

HEPFER: Yeah, the individuals.

PRIEST: They would be employed by an agency, a qualified agency.

HEPFER: Which also could be a DSN Board?

PRIEST: It could be a DSN Board, could be a qualified provider.

HEPFER: Okay. All right. So how did the Department go about making these changes back in 2009 I guess when it started?

PRIEST: And again, it's been two years. As I recall the changes were—the Waiver had been renewed by CMS for five years. That renewal period was expiring and it was time to renew the Waiver. As I recall there was a questionnaire or a survey that went out to families and then—and that information—there was a survey that went out to families and that's about all I remember about that and then the information that came back was used or considered when the change—when we started talking about changes to the Waiver.

HEPFER: Okay. And did you all announce the changes or the proposed changes back in '09?

PRIEST: Yeah, there were public meetings that were held about the changes, several of them around the State.

HEPFER: Did you attend those?

PRIEST: I did.

HEPFER: Can you give us some examples of where public hearings were held?

PRIEST: I'm sure there was one in Columbia. I recall one in Greenville. I recall one I believe in Bamberg. I seem to recall one in Spartanburg.

HEPFER: Okay.

PRIEST: There were others. I'm sure there were some in the low country but it's, again, it's been two years.

HEPFER: Okay. And do you know whether service coordinators were instructed on the changes?

PRIEST: Yes. DDSN would have instructed service coordinators about the changes once they were approved.

HEPFER: Okay, and were individual notices sent to individuals who would experience waiver reductions or limitations or reconfigurations?

PRIEST: Yes, as I recall they were.

HEPFER: Okay. Was there any other preparation that you can think of that was taken when the changes went into effect?

PRIEST: I...

HEPFER: It's been awhile?

PRIEST: It's been awhile, I, I don't recall.

HEPFER: Okay. One service we didn't talk about was ADHC services which are—can you explain what those are and give us the full name of ADHC services?

PRIEST: ADHC is Adult Day Health Care services and those are services that are provided in licensed adult day health care settings and there is a medical component to those services and they are designed as again, I don't have the definition in front of me to quote it from the Waiver, but they are services provided in a licensed setting to people who have a medical need.

HEPFER: Okay. I refer you to page 49 of the Waiver document which is Petitioner's Exhibit 5 I think, and those are all other services are they not, that's a list of services that can be provided under the Waiver?

PRIEST: Yes.

SCHINDLER: Excuse me, what page was that?

PRIEST: 49.

SCHINDLER: 49, thank you.

HEPFER: And all those services according to the situation would have been available to Mr.—or were available—or are available to Mr. Myers?

PRIEST: Correct.

HEPFER: As a participant in the Waiver.

PRIEST: Correct.

HEPFER: All right. Thank you, Ms. Priest. Please answer any questions that the Petitioner has.

SCHINDLER: Before Ms. Harrison gets it, can you show me that page? My page numbers seem to be cut off.

HEPFER: Oh no.

PRIEST: You want some help?

SCHINDLER: If you can just find the pages.

HARRISON: Do you have a sticky?

SCHINDLER: Yeah, I've got one, thank you.

PRIEST: It's at Appendix B.

HEPFER: C.

PRIEST: C.

SCHINDLER: Well, I may have just been in the wrong section. There may be a page number on it.

PRIEST: I think you are close.

SCHINDLER: Thank you. All right, Ms. Harrison. Thank you, Ms. Priest.

HARRISON: Okay. Ms. Priest, you say you have a Bachelor's in Social Work?

PRIEST: That's correct.

HARRISON: And where did you go to college?

PRIEST: Winthrop Univer—Winthrop College.

HARRISON: Do you have a graduate degree?

PRIEST: I do not.

HARRISON: What medical training do you have?

PRIEST: I do not have any.

HARRISON: And how long have you worked for DDSN?

PRIEST: Nineteen years, nine months.

HARRISON: And are you familiar with the notice that went out to the family members?

PRIEST: I seem to recall a notice but I—it's been—you're talking about the one that went out...

HARRISON: When the Waiver changes were implemented.

PRIEST: Two years ago. I have—I have seen it. I don't have it in front of me.

HARRISON: Did it—do you have it? Did it inform each individual how the Waiver reductions would affect that person or was it just a general summary of all the Waiver changes?

PRIEST: I don't recall it specifically. More than likely although I don't have it in front of me, it would have been general and instructed the person to contact their service coordinator for specific information.

HARRISON: Okay. Did that notice inform the individuals of what regulation or law the changes were being made under?

PRIEST: As I said, I don't have it in front of me and I don't recall.

HARRISON: Okay. What's the purpose of the Medicaid Waiver? Now—it was an MR/RD Waiver at the time, was it not?

PRIEST: It was.

HARRISON: And now it's changed, has it not? The name has changed.

HEPFER: Answer if you can.

PRIEST: We have changed the way we talk about people with disabilities in terms of people with disabilities have told us that they find the term mental retardation offensive. They would prefer intellectual disabilities. So...

HARRISON: So what's the Waiver program now?

PRIEST: As far as the way it is—has been submitted to CMS it is still entitled the Mental Retardation Related Disabilities Waiver.

HARRISON: Okay. And what's the purpose of the Waiver?

PRIEST: As I understand the purpose of the Waiver, the purpose of the Waiver is to provide services to people in order to prevent institutionalization.

HARRISON: Okay. Do you know who—when these Waiver amendments were being changed did you mention that there were surveys sent out, did you not?

PRIEST: Yes, I did.

HARRISON: Did those surveys inform family members that the reason that what they were doing was collecting information to change the Waiver?

PRIEST: I don't recall specifically what—I recall that there was a questionnaire or a survey. I don't recall the specifics of it.

HARRISON: But you wouldn't deny that it did not say this is going to be used to change the Waiver?

PRIEST: I don't recall what it said.

HARRISON: You don't recollect that it did.

PRIEST: I don't recollect that it did or it did not.

HARRISON: Okay. Who was involved in determining that the amendments were necessary?

PRIEST: The Waiver was being renewed.

HARRISON: And who was involved? The question was who was involved?

PRIEST: Who was involved in the—in writing the Waiver renewal?

HARRISON: In making the decisions about what changes would be made.

PRIEST: Staff made recommendations and as I recall they were presented to the Commission.

HARRISON: And what staff members worked on that? Did you work on that?

PRIEST: I did.

HARRISON: And what other staff members?

PRIEST: The Waiver coordinator would have worked on it whomever that may have been at the time. (Unclear) staff would have participated, financial staff.

HARRISON: Can you give me the names of the individuals?

PRIEST: I guess at that time financial staff would have been Tom Waring, Richard Winnick, Bill Barfield. I'm not recalling exactly who the Waiver coordinator was at the time and again when waivers are renewed for five year periods so probably at least a year or a year and a half prior to

renew—prior to the expiration of the Waiver approval, work begins on a renewal so it starts very much in advance and can go for a long period of time.

HARRISON: My—do you deny that the public was totally unaware of these changes until the meeting on June 4th—in June 2009.

PRIEST: I can't speak for what the public may or may not have been aware of.

HARRISON: Can you tell me anything that was sent out to the public prior to June 2009 to let them know what these changes ya'll had been working on for a year and a half?

PRIEST: I don't recall.

HARRISON: Okay. Now when DDSN, these changes, can the service coordinator decide to exceed those limits?

PRIEST: It is my understanding that when a limit is written into the Waiver, that is the limit that the Waiver funds.

HARRISON: Okay, so who can decide to exceed the twenty-eight hours a week personal care attendant? Who has the authority to do that?

PRIEST: It's my understanding that no one does.

HARRISON: Okay. Who can exceed the 240 hours of respite?

PRIEST: It's my understanding that no one.

HARRISON: Okay. Who has the authority to determine that even though one of the—now it, it—my understanding is the criteria for PT and OT under the Waiver was less restrictive than the State Plan criteria, is that right? For example—go ahead.

PRIEST: As was written in the Waiver, therapy services were an extended State Plan service which meant that the criteria that applied to children would then apply to adults who were enrolled in the Waiver. However, the State Plan does cover therapies for adults.

HARRISON: Okay, but is it not true that, that PT, OT, and Speech for children, the criteria is less restricted for them? Is the criteria the same for children and adults?

PRIEST: If you're asking me if the criteria for receiving a State Plan therapy for an adult is the same as the criteria for receiving a State Plan therapy for a child, it is my understanding they are not the same criteria.

HARRISON: Okay. Let's talk specifically about PT, OT, and Speech. A child under 21, what is the criteria to determine whether that child gets PT, OT or Speech?

PRIEST: I am not—I would not feel comfortable answering that because they are not Waiver services. They are State Plan services, therefore, they are covered for every child who has a Medicaid card. Someone from Health and Human Services would be better to answer that question because I am not an expert in the area of children's therapies or rehabilitation services provided through the State.

HARRISON: But you would agree that when those PT, OT, and Speech services were taken away from the Waiver, the criteria became more restricted.

PRIEST: At the time the decision was made DDSN was told that the services were available to adults through the State Plan.

HARRISON: Did you find out something different later?

PRIEST: It is my understanding that they are available to adults through the State Plan.

HARRISON: Prior to the amendments, if a person had a medical necessity determined by their doctor that they needed PT or Speech, would they have gotten that service?

PRIEST: Services typically would have been authorized by a service coordinator possibly, yes.

HARRISON: Based on what?

PRIEST: Based on a determined need.

HARRISON: And what was the criteria to determine that—prior to the amendments to the Waiver, what was the criteria to determine that Al Myers needed Speech?

PRIEST: I don't know. I don't know Al Myers' case specifically.

HARRISON: Okay, I'm sorry. An individual that needs speech, what was the criteria...

PRIEST: It would be based on the service coordination assessment.

HARRISON: So who makes that determination?

PRIEST: The service coordination—service coordinator would determine whether or not the service was needed.

HARRISON: Based on what?

PRIEST: Based on their assessment.

HARRISON: Okay. What role did the physician play in determining the need for Speech?

PRIEST: Under the Waiver and based on the authorization of services, we would have gone on an assessment of need.

HARRISON: Done by?

PRIEST: A service coordinator. Before the service was provided and the Medicaid rules for getting it, there probably was and again this is not my area of expertise, there would be the need for a doctor to also say that there was a need.

HARRISON: Okay, so...

PRIEST: Again, you're asking me questions about an area that I am not familiar with. I am not familiar about the authorization of services. I can tell—I mean about the authorization of therapy services and the physician's role in that. Through the Waiver we do an assessment of need using a service coordinator.

HARRISON: Okay, but you're in charge of Waiver services for the whole State, is that correct?

PRIEST: Correct.

HARRISON: Okay, so you don't know prior to the—prior to the changes, what role did the physician have?

PRIEST: The service coordinator could authorize the service. The service coordinator would authorize for example, if a service coordinator went into a home and met with the family and it was obvious that nobody understood what the person said then perhaps the service coordinator would make an authorization for a referral to a speech therapist for an

initial evaluation. Once the evaluation was done, if the therapist felt that the therapy was necessary then there would be—there would be the point in time that the physician could be involved to also authorize the service.

HARRISON: Okay, so if the physician determined that the service was needed prior to the changes, would the service coordinator authorize that?

PRIEST: I'm sure if the service coordinator was made aware that the physician felt that speech therapy was needed and she too determined that there was a need then the service could be authorized.

HARRISON: So could the service coordinator override the physician's determination?

PRIEST: My understanding of Waiver service and the authorization process is that yes, they can.

HARRISON: Okay. After the changes, after the way PT, OT, and Speech were removed from the Waiver, now this service coordinator can't approve that, can she?

PRIEST: She does not authorize State Plan services, no.

HARRISON: Okay. And...

PRIEST: The services are available to all Medicaid recipients.

HARRISON: Okay and to get PT and Speech you have to prove, do you not now, that you'd be hospitalized if you didn't get it?

PRIEST: I'm not familiar with that criteria per se'. I've seen it. I've read it. It's been a number of years.

HARRISON: And you're in charge of all MR/RD services for the State of South Carolina through DDSN?

PRIEST: I am. And when those—that information's needed I can look it up.

HARRISON: Okay. Did DDSN or DHHS promulgate any regulations approving the reductions in services?

PRIEST: No, not to my knowledge.

HARRISON: Okay. Was there any discussion about that?

PRIEST: Not that I was involved in.

HARRISON: Okay. So you don't know whether there was a discussion about should we promulgate regulations or not?

PRIEST: I do not.

HARRISON: And you're in charge of MR/RD services for the entire State?

PRIEST: That is correct. I was not involved in any conversation about promulgating regulations.

HARRISON: Okay. Now when these changes were made there were some changes to the—you reviewed the Waiver document. What role did you have in preparing the Waiver document?

PRIEST: I put together DDSN's recommendations to—recommendations for changes and shared them with Health and Human Services.

HARRISON: Okay. And the—that Waiver document contains rates, does it not, that are paid for various services?

PRIEST: It does. I do not do that part of it. That's a different staff person.

HARRISON: Could I borrow your (unclear), Rick? I didn't...

HEPFER: Yeah, sure.

HARRISON: Okay, and the rates that are paid for services, can you—can you explain there's five different years here on the back are there not?

PRIEST: I believe there are because it's a five year renewal.

HARRISON: Okay, so, so you're not familiar with the rates paid for the various services?

PRIEST: I'm familiar that they're part of it but I don't complete that part of it. It's considered a financial document that's completed by financial staff at DDSN.

HARRISON: Okay. Are you aware that the rate for ICFMR respite went up from $157 a day to $270?

VOICE: Are ya'll expecting somebody else?

SCHINDLER: Yes.

VOICE: Okay. She's downstairs. I'm going to go get her.

SCHINDLER: Thank you, thank you.

HARRISON: Are you aware that they increased the rate paid for ICFMR respite by 70 percent?

PRIEST: I was not specifically aware of it, no.

HARRISON: Okay. So you weren't aware that there was a tremendous increase in the rate they pay for ICFMR respite?

PRIEST: No.

HARRISON: And you're in charge of the MR/RD services for the State?

PRIEST: Yes.

HARRISON: So you didn't know that they increased the rate that they paid for ICFMR respite?

PRIEST: I did not complete that portion of it and I did not recognize that it was done, that it changed.

HARRISON: Okay, so you weren't aware that it changed.

HEPFER: She just testified to, Hearing Officer.

HARRISON: Okay. What is the rate paid to DDSN for in-home respite?

PRIEST: I don't know.

HARRISON: Who makes the determination that the rate is sufficient to provide enough services so that people can actually—if you paid $5.00 an hour would you expect many people to take that job?

PRIEST: Since $5.00 an hour is below minimum wage, I would expect not.

HARRISON: If you paid $12.00 an hour, do you think more people would take—be available to take that job than if you paid $7.00.

PRIEST: I would suppose.

HARRISON: Okay. And, and the individuals who actually perform the respite services, well, let's talk a little bit. There was a problem, wasn't there, that came up about a year ago, year and a half ago about how DDSN was doing respite?

PRIEST: There was an IRS decision about respite, yes.

HARRISON: And tell me about that.

PRIEST: Again, I was not intimately involved in the decision. I do not operate a respite program so I can talk to you in generalities about the decision but I do not know the specifics.

HARRISON: Okay, but respite is what you're saying one of the primary components of the—of the MR/RD Waiver.

PRIEST: It is a Waiver service, yes.

HARRISON: Okay, and you're saying is it not true that DDSN for people who have severe disabilities replaced most of the PCA hours with respite hours?

PRIEST: We replaced supervision. We tried to implement personal care based on the way the service is defined which is hands-on care. And we tried to provide supervision to people who needed it based on the service that provides supervision which is respite.

HARRISON: Okay, here's my question. Would Al Myers previously he had a larger number of PCA services, did he not?

PRIEST: I don't know Al Myers' case specifically.

HARRISON: Okay. So you're not—you don't know anything about Al Myers' case?

PRIEST: I have—I am not his service coordinator. I have not reviewed his record.

HARRISON: Okay, who made the decision that Al Myers specifically could remain in the community with PCA services being replaced with respite services?

PRIEST: I don't know how to answer that question.

HEPFER: Can you rephrase the question?

HARRISON: Okay, did you look at the services under the new Waiver and consider Al Myers' needs and who made the decision that it would not affect his ability to stay in the community if you reduce his hours?

PRIEST: I haven't looked at Al Myers case.

HARRISON: Who at DDSN has looked at Al Myers' case?

PRIEST: He has a service coordinator who is primarily responsible for reviewing his needs or determining his needs.

HARRISON: Did anyone other than the service coordinator evaluate his needs to determine whether that was sufficient for him to remain in the community?

PRIEST: I don't know.

HARRISON: I'm sorry?

PRIEST: I don't know.

HARRISON: Okay, what were the reasons—you're, you're saying that as I understand it and correct me if I'm wrong, that the reason for substituting respite services for PCA services was that people were—were having PCA

caregivers do things they weren't supposed to do, is that correct? What was the reason for the change?

PRIEST: I don't think that there's a reason for the change, okay? Not a specific reason or the only reason for the change. What I said in earlier testimony was that the definition of personal care is that it is hands-on care and that what we found was that often part of what the personal care aide was doing was supervising people or waiting for a task to be needed which is not part of the definition of the service of personal care.

HARRISON: Okay, the letter—are you familiar with the letter that—the letter that Dr. Buscemi sent in response to Ms. Myers' request for an appeal? Are you familiar with this letter?

PRIEST: Not specifically.

HARRISON: Okay, if you'd take a look at it.

SCHINDLER: Ms. Harrison, is that a letter I already have in my file?

HARRISON: And it is not. It's—we're going to need to...

HEPFER: Well, you have the—this is the—I believe the record of the previous case.

HARRISON: Oh, it is. I'm sorry, you're right.

SCHINDLER: I thought I probably already had it.

HEPFER: So you have that.

SCHINDLER: Okay. What's the date on that letter?

HEPFER: That record and it's page 51 of that record.

SCHINDLER: Okay, thank you. Actually we're going off the record for a moment. We are back on the record. I want to go ahead and introduce a new person who's here for the Petitioner, Ms. Lennie S. Mullis who's a Psychological Consultant. And now we're ready to proceed with Ms. Harrison's cross-examination of Ms. Priest.

HARRISON: Okay, thank you. You're looking at the letter from Beverly Buscemi dated, is that...

PRIEST: January 13, 2010.

HARRISON: Okay. Can you read to me the part in that denial that says that the reason is because, because the PCA services don't include supervision?

PRIEST: It doesn't say that.

HARRISON: Okay, what does it say that the reason—what is the reason according to that letter for these reductions?

PRIEST: The letter says, as you may know over the last year, DDSN has suffered devastating budget reductions. As a result of those reductions limits caps were placed on services in the MR Waiver. Approval of these limits or caps was obtained from CMS. These approved limits cannot be exceeded and must be applied to all MR Waiver participants.

HARRISON: Does this letter in any way inform anybody that there's a way to exceed those limits?

PRIEST: No, it does not.

HARRISON: And your testimony I believe is that there is no way to exceed those limits?

PRIEST: To my knowledge, no.

HARRISON: Okay.

PRIEST: Let me clarify—let me—if the decision, if, if, if prior to this letter if the Respondent asked that the services remained in place, they were entitled for them to be left in place so those people would be exceeding the limits.

HARRISON: Just during the appeal?

PRIEST: Just during the dependency of the appeal. So just to clarify.

HARRISON: Okay. So what knowledge, personal knowledge do you have that the service coordinator made a determination that Myers would be able to remain in the community if PCA was replaced with respite?

PRIEST: What personal knowledge—would you repeat the question?

HARRISON: What personal knowledge do you or anyone at DDSN have that if you switch PCA services to respite that he'll be able to remain in the community?

PRIEST: I don't have any personal knowledge of Mr. Myers' situation.

HARRISON: What knowledge do you have that doctors' opinions were considered in replacing the PCA services with respite?

PRIEST: Regarding Mr. Myers?

HARRISON: Right.

PRIEST: I don't have any personal knowledge of Mr. Myers.

HARRISON: Okay, what—do you do any training for service coordinators?

PRIEST: I have in the past.

HARRISON: Okay, what training do you provide to service coordinators about, about the deference they give to physician's orders for PCA and respite services?

PRIEST: We don't.

HARRISON: Okay. Are the service coordinators bound to comply with the doctors' orders as to how many hours they need?

PRIEST: No, they are not.

HARRISON: Okay, where would I find the criteria that they go to to evaluate a doctor's orders to decide whether they should comply with it or not?

PRIEST: There's no written criteria for that.

HARRISON: Okay. How many individuals have moved into nursing homes or ICFMR facilities since the reductions were implemented?

PRIEST: None to my knowledge.

HARRISON: What about ICFMR respite? Now previously was there any cap on respite services?

PRIEST: No, I don't think there was.

HARRISON: Previously was there any cap on PCA services?

PRIEST: No.

HARRISON: Okay. Now you said that ya'll did away with the respite service that cost $70 a day, about $70, how much was the daily respite, what did ya'll pay?

PRIEST: I don't know.

HARRISON: Okay. What analysis did you do as the Director of the MR/RD Waiver program or the division that does that, what analysis did you do when ya'll changed the reimbursement scheme for respite providers to assure that it would enlist enough providers to meet people's needs?

PRIEST: I don't recall that any was done and if it was done, it was not done by the MR Division.

HARRISON: Okay. What study did the Department do to consider the cost effectiveness of the amendments? What study did you do, cost analysis, is there a cost analysis study? Is it not true that if you take one service away, people are likely to need another service?

PRIEST: Possibly.

HARRISON: Okay, so if you take PCA services away, did many of the people who previously weren't going to workshops start going to workshops? Have you increased the number of people going to workshops?

PRIEST: Not to my knowledge.

HARRISON: Okay. So what happened to these people when you took those hours away? Did they—you didn't increase the number that were going to other services? You just withdrew those services?

PRIEST: People—there was an increase in respite because many of the people that were getting personal care truly needed supervision so there was an increase in respite.

HARRISON: Okay, are you familiar that in many counties families have been told that they are forced to become the employer of the respite caregiver?

PRIEST: No, I'm not familiar with that.

HARRISON: Okay. Did your Agency—did your Division have anything to do with the form that was filled out that in training Boards about the tax form that's filled out to be a respite (unclear)?

PRIEST: My Division did not have anything to do with that, no.

HARRISON: Okay. Who determines medical necessity in your, in your program?

PRIEST: We don't determine medical necessity.

HARRISON: Who determines medical necessity?

PRIEST: We don't determine medical necessity.

HARRISON: For the MR/RD Waiver Program, who determines medical necessity?

PRIEST: As I understand the Waiver, the way the Waiver document is written, the service coordinator is the one who assesses needs. To me there's a difference between determining medical necessity and assessing needs. The way the Waiver as I understand it operates is that there is an

assessment of need that is done by the person with the qualifications listed in the Waiver document which in this case is a service coordinator. The service coordinator does an assessment of need—does an assessment to determine what needs the person has and then develops a plan or authorizes services to meets those needs.

HARRISON: Does Medicaid not require that there be a medical necessity for a service before it's provi—before they pay you for it?

PRIEST: My understanding of Waiver services is that it is operated as I've explained.

HARRISON: Okay, but does Medicaid not require that there be a medical necessity before you bill Medicaid for the service?

PRIEST: Are you asking me about State Plan services or are you asking me about Waiver services?

HARRISON: I'm talking about the Federal law.

PRIEST: I'm asking you are you asking me about Waiver services or are you asking me about State Plan services? As I understand the Waiver, the service coordinator does the assessment. The service coordinator develops the plan and the service coordinator authorizes the service.

HARRISON: Okay, my question is, does CMS not require that services be medically necessary before they pay for them?

PRIEST: As I understand Waiver services, the service coordinator authorizes the service based on the assessment.

HARRISON: My question was does the Federal government require that services be medically necessary before they pay for them?

PRIEST: Then I guess my response is I don't know.

HARRISON: Okay. Okay, after the ALJ reversed the decision requiring a hearing, you're familiar that Al's service, this case was consolidated with three other cases, are you familiar with that?

PRIEST: I am not.

HARRISON: Okay. Are you aware that the Waiver services for the other individuals has been continued?

PRIEST: I am not.

HARRISON: Okay. What role, withdraw that. Okay, how were Al Myers' individual needs considered in making the determination to reduce his PCA services?

PRIEST: I don't know anything about Mr. Myers' situation.

HARRISON: What would you expect—how would you expect—you provide training for service coordinators.

PRIEST: Occasionally.

HARRISON: Okay, how do they—what is the basis of the assessment? How do you train them to do assessments?

PRIEST: What we do—there is instructions for the assessment. We expect that the service coordinator speak with the family, speak with available service providers, use any available information which may include medical information and based on that complete an assessment document.

HARRISON: What deference do you expect the service coordinators to give to the physician?

PRIEST: I expect them to weigh it with the same—like any information that we get from a teacher, from a parent, from a familiar caregiver.

HARRISON: Okay. So it's given the same amount of deference?

PRIEST: I'm not really sure how to answer that. We don't tell them to weight it more heavily. We don't tell them to discount it. We tell them to consider it.

HARRISON: Okay. Now help me understand. You're saying that previously that PCA providers were, were just kind of hanging around the house, not doing what they were supposed to do?

PRIEST: I don't believe I said that.

HARRISON: Okay, help me—you, you were saying that the waiting around part isn't part of what a PCA does.

PRIEST: My understanding of the scope of service and the way the service has been explained to me by Health and Human Services staff in terms of what South Carolina Medicaid expects from personal care is that it is the act of hands-on provision of service.

HARRISON: So under the Waiver limits, how many hours a day of PCA services can a person receive?

PRIEST: It's 28 per week. If you divide that by seven it would be four.

HARRISON: Okay, four hours a day. Okay, so does a Waiver participant—and so that has to be—that's normally scheduled in advance? You have a, you have a—does a service coordinator provide a schedule for when those services are provided?

PRIEST: No, the service coordinator does not provide a schedule to the agency of when they are provided.

HARRISON: Okay, so could Carol Myers choose on Monday to use all 28 hours in two days?

PRIEST: No ma'am.

HARRISON: How would she have to space those out? How is it determined how those services are used?

PRIEST: It would be based on need. Again, if you—if the need is that he need—the service to be provided is the person for example needs to be bathed, their hair groomed, their teeth brushed, breakfast fed, a load of clothes washed, then that may equate to four hours. But that's four hours a day per se'.

HARRISON: Okay.

PRIEST: The reason you can't bank it is because the same needs are there every day. I mean if the expectation is the same every day, if it takes four hours to do the same thing—to do something on Monday, then the expectation is that it would take the same amount of time to do it on Tuesday.

HARRISON: So you couldn't bank those hours? You couldn't use more than that number a day, is that correct?

PRIEST: It is my understanding you're not supposed to do that.

HARRISON: Okay. What does Al Myers do if he has a bowel movement not on that set schedule?

PRIEST: The Waiver, apart from residential habilitation is not intended to provide 24-hour care for anybody and the Waiver document says that. So the expectation is not that 24-hour care be provided. Certainly there are

people in the Elderly and Disabled Waiver and other waivers and in this waiver who are going to have needs apart from the four hours of service that are provided. That is a means of assistance to lessen the burden on the caregiver per se' to help the caregiver when they can't do it but it's not intended to provide all of the care that he needs.

HARRISON: Okay. And let's just talk about the MR/RD Waiver. If the parent can't lift the individual and the individual has a bowel movement outside of those four hours, how is that provided?

PRIEST: In a situation like that then we would look at the entire package of services. Could a lift be of assistance? You know, a modification to the home, assistive technology that would assist the parent to be able to lift them to provide the care the person needs. There are twenty some services in the Waiver. Even with limits on personal care there are other services that could be put in place to assist.

HARRISON: Okay. Can a personal care attendant provide tube feeding?

PRIEST: It's my understanding that they can't.

HARRISON: Okay, can a respite provider provide tube feeding?

PRIEST: It's my understanding that they can't.

HARRISON: Okay. You have a—you mentioned adult day health care services, and where would I find—before I get into the adult day health, where would I find that regulation about what PCA's not providing tube feeding?

PRIEST: That would be the Nurse Practice Act, South Carolina Nurse Practice Act.

HARRISON: Okay, with ADHC services how many hours of those services provided a day?

PRIEST: I'd have to look to be precise but I think it's around five.

HARRISON: Okay. Let's take someone with—do you understand the level of disability of Al Myers? What do you understand about Al Myers?

PRIEST: Very little.

HARRISON: What do you know about him?

PRIEST: Very little. I know he is a Waiver participant. I know some of the services that he received.

HARRISON: What is his disability?

PRIEST: I believe he is eligible through intellectual disability or has an intellectual disability. I know very little more about him.

HARRISON: Is he able to walk?

PRIEST: I don't know.

HARRISON: Is he able to talk?

PRIEST: I don't know.

HARRISON: Is he able to bathe himself?

PRIEST: I don't know.

HARRISON: Is he able to prepare his food?

PRIEST: I don't know.

HARRISON: Is he able to eat food?

PRIEST: I don't know Mr. Myers.

HARRISON: Okay. And you're saying you don't have anything to do—you don't know anything about how the rates that are paid for...

PRIEST: I don't set rates. That would be fiscal staff of DDSN.

HARRISON: And as Director...

PRIEST: In conjunction with fiscal staff of DHHS.

HARRISON: And as the Director of the program, you didn't get into any discussions of how—how much is paid—look on the Waiver document, how much is paid for respite services per hour?

PRIEST: Respite in-home hourly $10.50.

HARRISON: How much is paid for PCA services? PCA.

PRIEST: Personal Care II?

HARRISON: Right.

PRIEST: $16 per unit.

HARRISON: Okay, this...

HEPFER: What year, what year are you in?

PRIEST: Year one. I just turned to year one.

HEPFER: All right, thank you.

HARRISON: Is that the amount paid to the individual?

PRIEST: That's—I don't—I don't know. Again, I don't do these tables.

HARRISON: Okay, but as the Director of the MR/RD Program...

PRIEST: I don't—I'm not a service provider, okay, so I don't operate a personal care agency and I don't operate an agency that is a respite agency so I don't pay staff. And I am not necessarily privy to the economics of hiring and paying staff and what providers typically do with paying staff.

HARRISON: Okay, but the Agency, what, what did the Agency do to assure that the rates were sufficient to enlist enough providers? Have you done any study—do you have any studies that you've done about rates?

PRIEST: No. I don't, no I don't.

HARRISON: Okay, were you involved in any meetings about the rates?

PRIEST: No, I was not.

HARRISON: And were there any discussions when you made these amendments about how switching from PCA to respite would affect the availability?

PRIEST: Not that I recall.

HARRISON: Okay. Okay, the problem with IRS was that respite, that the DDSN or the DSN Boards were not paying the FICA taxes for respite workers, wasn't it?

PRIEST: As I've said I'm not familiar with that decision. I don't feel really comfortable talking about it because I don't know the in's and out's of it.

HARRISON: Are you aware that that was a problem?

PRIEST: I am aware that there was an IRS issue.

HARRISON: Are you aware that DDSN and the DSN Boards were not paying FICA on respite workers?

PRIEST: I think I heard that but hearing that and being intimately involved in it and being able to answer your questions about it are two different things.

HARRISON: Okay. So you're not aware of the instructions that were given to parents that they would need to become the respite employer?

PRIEST: No, I'm not.

HARRISON: You're not, you're not familiar that parents were told they had to become the employer?

PRIEST: Specifically, no, I am not.

HARRISON: Okay. Tell me about the difficulty of care rate for respite services.

PRIEST: The difficulty of care rate is a rate that prior to the waivers, meaning in the late 80's and early 90's, prior to the waiver, DDSN had a method to pay a respite provider more money when they proved that the person's care was greater. DDSN has not utilized the difficulty of care rate since it instituted the band payments.

HARRISON: Okay, so respite providers have not been paid a difficulty of care rate if the individual has more greater needs?

PRIEST: DDSN pays a band payment to the provider agency. What the provider agency chooses to pay the caregiver or decides to pay the caregiver is not within DDSN's control.

HARRISON: Okay, so...

PRIEST: Or not dictated by DDSN I guess is a better way to say it.

HARRISON: Are you familiar with the qualified provider request for proposals?

PRIEST: I am.

HARRISON: Does it not have a rate that providers must pay a minimum of?

PRIEST: I believe it does for direct care services, yes.

HARRISON: And how much is that?

PRIEST: Eight something, I don't know.

HARRISON: Okay, I believe it's at least $8.31, isn't it?

PRIEST: I don't know.

HARRISON: Okay, but it's more than $8.00?

PRIEST: I remember the $8.00. It's more than $8.00. That's all I know.

HARRISON: Does that request for proposal also require the providers to provide Worker's Comp and unemployment benefits?

PRIEST: I don't remember specifically how it's worded.

HARRISON: But that's the—that's the contract document for your Program, isn't it? Isn't that the contract for Program...

PRIEST: That's the contract between DDSN and a provider.

HARRISON: But that's the way you get providers into the system, isn't it? Into your program?

PRIEST: The way we get provider—service providers statewide is through that process, yes.

HARRISON: Okay, and that process requires the—a minimum rate to be paid to the direct caregiver, is that right?

PRIEST: That's correct.

HARRISON: And that also, that process also requires the provision of Worker's Comp and unemployment, does it not?

PRIEST: I'm telling you that I do not recall off the top of my head what it says about those two areas.

HARRISON: Okay, but it's the—it's the contract ya'll use to get providers for your Program.

PRIEST: It is. It's the contract that we use.

HARRISON: Okay, and you don't know whether that contract for providers for your Program requires them to have liability insurance, to show proof of liability insurance?

PRIEST: I can go look at it and tell you but sitting here without the benefit of having it in front of me I don't want to answer to say it requires this or it requires that.

HARRISON: How do you—what guidance do you give to the Boards about how much they pay the respite caregivers? Are they required to pay that amount?

PRIEST: I don't give guidance to the Boards about what they pay respite caregivers.

HARRISON: How much do the Boards pay respite caregivers?

PRIEST: I don't know. That's not my area of expertise. I don't deal with what providers pay their staff.

HARRISON: Do you know whether respite caregivers are paid less than the ICFMR workers are paid?

PRIEST: I do not know.

HARRISON: So you didn't do a study of that to determine whether the rates are high enough to enlist enough providers?

HEPFER: She's already testified...

PRIEST: Still didn't do a study.

HEPFER: ...three or four times that she didn't. This is getting a little cumulative, Madam Hearing Officer.

HARRISON: Okay, tell me, there—in these—I do a number of these appeals and what we've been finding out is that there's some communications that are not copied to the attorney or the family between your Agency and the Office of Appeals and Hearings. Can you tell me how that works? Are you aware of the memos from Jacob Chorey to the Hearing Officer?

PRIEST: I'd have to see one.

HARRISON: Can you tell me what this is?

HEPFER: We're on page 44 of the record (unclear) previously.

SCHINDLER: Thank you.

PRIEST: As I recall, the Division of Appeals and Hearings asked specifically for information about what was received prior to and what was the effect afterwards.

HARRISON: When—how did that communication take place?

PRIEST: I don't know. It did not come through me so I do not know.

HARRISON: Does Jacob Chorey work for you?

PRIEST: He does.

HARRISON: Okay, so somehow there was communication between the Office of Hearings and Appeals and Jacob Chorey or—so you weren't aware of this?

PRIEST: Like most of the—not speaking specifically about this, the Division of Appeals and Hearings communicates through our Executive Staff. An Executive Staff would then ask individual staff members to do whatever needed to be done.

HARRISON: So what Executive Staff do they communicate with?

PRIEST: That would be Kathy Lacey.

HARRISON: Okay, so help me understand how this process works. So the Office of Appeals and Hearings calls Kathy Lacey or she calls them, how does that work?

PRIEST: I don't think that it's a matter of calling back and forth. There are hearings that need to be scheduled and occasionally there's information that needs to be shared so if an appeal is received at Health and Human Services and information is needed, it's my understanding although I am—they're not sent to me, that an email would be sent saying please send this information.

HARRISON: So the email would be sent from the Office of Appeals and Hearings to Kathy Lacey?

PRIEST: Correct.

HARRISON: And then that's what generated this, this memo...

PRIEST: I don't know that...

HARRISON: ...from your employee?

PRIEST: I don't know that. That's what I—that would be my suspicion. I don't know exactly what.

HARRISON: So the Office of Appeals and Hearings contacted Kathy Lacey and she went around you to Jacob Chorey?

PRIEST: She could have.

HARRISON: Okay, have you had any discussions with Jacob Chorey after the Office of Hearings and Appeals contacted Kathy Lacey?

PRIEST: About?

HARRISON: About this case or...

PRIEST: No.

HARRISON: So you're not involved in that loop?

PRIEST: Not necessarily, no.

HARRISON: Okay. Can you explain to me why the, the family member or the attorney if they have one, are not provided this information?

PRIEST: No.

HARRISON: Okay, in the letter we were looking at and maybe I've covered this. I'm sorry. Can you recite to me the part about that letter that says the reason for the changes is because of the overuse of PCA?

PRIEST: As I answered before, it doesn't say that.

HARRISON: Okay. So you don't know why Al's needs are different from Chip's and Michelle's and Susan's.

PRIEST: I don't know Al.

HARRISON: Okay. Do you know anything about the other three people...

PRIEST: I do not.

HARRISON: ...that are in this consolidated case? Okay. Do you know whether these other individuals, Chip, Michelle and Susan, have been able to remain in the community?

PRIEST: I don't know Chip, Michelle and Susan. I...

SCHINDLER: Ms. Harrison, excuse me, I'm going to interrupt and say that this hearing is just about Mr. Myers. The Judge consolidated some cases but the other three aren't being heard today. Only Mr. Myers' case is being heard today.

HARRISON: Our point with all due respect is that these were consolidated by the ALJ and they were remanded as a consolidated case.

SCHINDLER: And the other three aren't being heard today so today we're just going to hear testimony on Mr. Myers' case.

HARRISON: Well, it's important as to Mr. Myers' case that the services for the other individuals were continued and Al Myers' services—Al Myers was instructed—was informed that his services would not be continued so the ALJ consolidated the case making it one and remanded it as a consolidated case so I think it's very relevant in this case that the other three individuals whose services were reduced below the rate they're getting now, their services were continued but it was only Al Myers' services that were reduced. So we think that's a very important comparison. Why Al Myers' services were...

SCHINDLER: I understand that but today's hearing is going to be about Mr. Myers.

HARRISON: Okay, well we, with all due respect, we feel the need to get into the record the fact that the other—it's one consoli—when we go back up to the ALJ if we need to, it's, it's, it's been one consolidated case.

SCHINDLER: And do you have any more questions for Ms. Priest? You have a chance to finish that answer Ms. Priest, I'm sorry to interrupt.

PRIEST: I don't remember the question now.

HARRISON: Okay, after—the decision was made, was it not prior to June 2009 to reduce these services?

PRIEST: I don't recall.

HARRISON: Okay, were you at that meeting, the large meeting at Richland Hospital where about 150 parents showed up?

PRIEST: I don't recall.

HARRISON: You don't recall?

PRIEST: I go to a lot of meetings. I've been at several meetings at Richland Hospital about a lot of different cases. I don't recall that one specifically. Could have been there.

HARRISON: Okay. Sorry, I need just a minute. Okay, I think you've answered this. With the 28 hour limit, are there any provisions or standards on how to provide more than 24?

PRIEST: Through the waiver.

HARRISON: Right.

PRIEST: No.

HARRISON: Okay. Tell me about PASRR.

PRIEST: PASRR's not my area of expertise. I don't do PASRR.

HARRISON: Okay, who does PASRR?

PRIEST: That would be (Unclear) Cooper.

HARRISON: Okay. What do you know about PASRR?

PRIEST: Very little.

HARRISON: Okay, when a person who's on the Waiver is no longer able to stay at home, isn't DDSN required to do an evaluation?

PRIEST: I don't know.

HARRISON: You don't know?

PRIEST: That would be about PASRR?

HARRISON: Well, I'm asking you...

PRIEST: Is there a question about PASRR?

HARRISON: Is DD—if a person who's been on the Waiver for years is no longer able to stay in the community, is there an evaluation that has to be done?

PRIEST: If the person is requesting to be placed in an ICFMR, there would be an evaluation that was done.

HARRISON: And tell me about that.

PRIEST: And that would be by the service coordinator and by the District Office and to evaluate the most appropriate placement when you're being placed in an ICFMR.

HARRISON: What about when a Waiver participant is forced to go into a nursing home?

PRIEST: This—the level of care in this Waiver is ICFMR. This Waiver includes services like residential habilitation which can be provided 24 hours a day so I don't know that we've ever had anybody that has chosen to go to a nursing home and I don't know what else to say.

HARRISON: But it's your opinion that the services that were being provided were sufficient to keep that from happening?

PRIEST: It is my opinion that the package of services available through the Waiver is sufficient to keep someone from being institutionalized in an ICFMR.

HARRISON: Okay, what about—the ADHC services, if a person has ADH service—Adult Day Health Care services, that's for five hours a day, is that correct?

PRIEST: Correct.

HARRISON: Okay. Is that person also able to get nursing services?

PRIEST: The A—it is my understanding that the scope of services for ADHC requires nursing, a nurse be present.

HARRISON: Outside those five hours?

PRIEST: That is a—ADHC is a service that is provided in a facility. That facility is required to have nursing.

HARRISON: Okay, so someone like Al Myers, what hours would he have that service?

PRIEST: Whatever the hours of operation are for the service. I don't know what they are for Al which whatever one was doing.

HARRISON: Normally what are the hours of an ADHC?

PRIEST: Usually during the day. Typically during the day.

HARRISON: For how many hours?

PRIEST: For five to six hours depending on the operation.

HARRISON: Okay. If a person requires tube feeding, is that normally—how many times a day does someone who requires tube feeding require that service?

PRIEST: I don't know. I'm not an expert in tube feeding. I know that there are some people who are on continuous feed pumps and there are some people that get it as in addition to what they consume by mouth so I guess the answer to that would be in my opinion, it varies.

HARRISON: Okay, if someone like Al Myers needed to be tube fed at four different times throughout the day and it had been ordered by his physician that he has tube feeding during these hours, and if these hours—I just need the hours, what are the hours you tube feed him?

MYERS: I'm thinking about that.

HARRISON: Early in the morning, at lunch it could be done at the ADHC. When he returns from ADHC for supper and at night. If we have somebody who needs tube feeding five times a day, how can those needs be met under the current waiver?

PRIEST: There could be a mix of service that includes the care that the family provides, personal care, nursing, or the person could be in residential habilitation. You could also include a day service like ADHC. Some of our day programs have nurses available for tube feedings.

HARRISON: Okay, here's my question. If a person is in an ADHC facil—or day program, and if that person needs to be fed at seven in the morning, at in the afternoon and in the evening, and there is no parent that can do that, how does that person remain in the community?

PRIEST: If the person is not able—if the person has no family support, there is no one that is going to assist in his care and they need—and they cannot perform those skills alone, then that person would likely not be able to have his needs met through the Waiver apart from residential habilitation which is an option through the Waiver.

HARRISON: Okay, is residential habilitation provided in the home?

PRIEST: Residential habilitation is provided in a licensed facility or in an apartment.

HARRISON: Okay. Could Al Myers get residential habilitation in his own home?

PRIEST: If it were his home, that might be a possibility depending on his ability. We have people who have their own home who are able to supervise themselves and care for themselves and they get residential habilitation on an hourly basis.

HARRISON: And how many hours of residential habilitation can they get?

PRIEST: There is not an explicit limit.

HARRISON: So could a person, if Al was in his own home, do you have people that get 24/7 care under residential habilitation?

PRIEST: We have people who get daily residential habilitation.

HARRISON: Do you have people who have someone one on one with them 24/7?

PRIEST: No, we do not that I know of.

HARRISON: So there's no one in the DDSN system who receives 24/7 through residential habilitation?

PRIEST: Your question was whether it was one to one care and the answer to that was to my knowledge I don't know of anyone who has 24 hour one on one care provided through the Waiver.

HARRISON: Are you familiar with the audit that was done in 2006 by HHS?

PRIEST: You would have to be more specific.

HARRISON: Okay, there was an audit done of the DDSN Waiver by HHS that showed that there are some people whose budgets are $150 - $160 thousand dollars, do you recall that?

PRIEST: Vaguely, yes.

HARRISON: And did that audit not say that the reason for those high rates for those individuals was that they required one on one supervision?

PRIEST: Okay, perhaps it did.

HARRISON: So are you saying now that there is no one that has that level of supervision through the Waiver?

PRIEST: What I said was to my knowledge, there's not. I am not aware of any one person in particular who gets 24 hour one on one in a non-ICFMR setting with residential habilitation through the Waiver.

HARRISON: But if Al were in his—okay, I withdraw that. Okay, are you aware of any change in the needs of Al Myers between 2009 and now?

PRIEST: I'm not aware of Al Myers.

HARRISON: Okay. Does a person in an institution have to wait until a specific hour to have his or her soiled diaper changed?

PRIEST: Not to my knowledge, no.

HARRISON: Would that be changed immediately?

PRIEST: I can't speak specifically for what would or would not happen in an ICFMR. I can speak to my knowledge of the ICFMR regulations and say that if a facility was found to only change people on a predetermined schedule rather than when they needed to be changed, the facility would be in great jeopardy of losing its' license.

HARRISON: Okay. So how are the needs different for being changed if a person is living in the community? How are the needs different?

PRIEST: I'm not sure I understand your question.

HARRISON: Okay. The person in an ICFMR, if he has a major accident, you can't wait until 2 o'clock to change him, is that right?

PRIEST: That's correct.

HARRISON: Okay, so if a person is only receiving four hours a day and a PCA is not coming in until a set time, how are that person's needs any different?

PRIEST: If the person has needs for incontinence care and a personal care aide is provided during specific times and the person has been assessed to have needs beyond that which includes supervision, respite could be provided

and again, respite is care provided in the absence or need of relief of the caregiver and that is all care and it would include those things that are supervise—that are personal care in nature. So if during the course of respite there was a diaper to be changed, the expectation would be that the diaper be changed during respite. If there's an—if during the course of providing respite, there are leisure activities that the caregiver would typically provide, then that's an expectation. Supervision is a big part of what caregivers routinely provide.

HARRISON: Okay, but what happens if the parent can't find someone willing to work for that low rate?

PRIEST: The service coordinator's responsibility is to assess the need. The service coordinator's responsibility is to assist the family and to find a provider. People who are in the waiver, if they are unable to find a provider and there is no caregiver that is willing or able to provide the care, then they would have to look at a different service like residential habilitation.

HARRISON: Which would require them to leave their homes.

PRIEST: Perhaps.

HARRISON: Tell me about an augmented communications device. How is it that that's provided through the Waiver?

PRIEST: I'm thinking that a device itself might be—might could be called assistive technology.

HARRISON: Okay, and that's under your section.

PRIEST: No, that is a Waiver service.

HARRISON: Okay. Tell me about assistive communications devices. What do they do?

PRIEST: They assist the person to communicate.

HARRISON: And are there different kinds?

PRIEST: Yes.

HARRISON: Okay. Are the needs different if a person is not able to use their arms?

PRIEST: Yes.

HARRISON: And tell me about that.

PRIEST: If a communication device requires a button to be pressed and a person can't press a button then obviously something else would have to be configured.

HARRISON: So what kind of—what kind of device—describe the device they would need if they can't use their arms or legs.

PRIEST: I'm not an expert in devices. There are a lot of different assistive technology products available on the market so it would be a matter of researching to try to find what was appropriate.

HARRISON: How would, how would they be able to use assistive communication if you can't use your arms and legs?

PRIEST: I beg your pardon?

HARRISON: If you can't use your arms or legs, what type of device do you need? I mean what...

PRIEST: I don't know. You'd have to do the research and find what was best fit for the person. There are a lot of kinds.

HARRISON: Is it not true that there's an eye gaze device?

PRIEST: I don't know. I suppose there is.

HARRISON: But that's in your Division. Is there somebody over you that would...

PRIEST: Ms. Harrison, there are millions of assistive technology devices. They are created every day. If there's an eye gaze one, I'm sure there is, I'm just not personally aware of it.

HARRISON: In order to get a device, does one not need a speech and language assessment?

PRIEST: I don't recall. I would—if someone has had a device that they have used successfully for a number of years, it could be replaced, his assistive technology without an evaluation. If you're talking about a new piece of equipment, if they've worked with a provider and they've used the equipment and it works for them, it could be purchased without a speech or language evaluation.

HARRISON: So you're saying there's no need for a speech or language evaluation to get—for the Waiver to pay for an assistive communication device?

PRIEST: That is not a requirement that I am aware of under the Waiver.

HARRISON: What is—if you don't have one, what is—how do you go about—where do I find the regulations that would show me how to get a device, the criteria you use to get a device?

PRIEST: The Waiver Manual itself is on the internet and you can look under assistive technology which is specialized medical equipment and assistive technology. That service defines assistive technology is anything that allows the person to perceive, control and communicate with their environment. Certainly, no one wants to waste money by buying things that they don't know whether it will work or not. Most companies that provide devices will allow a person to use it on a trial basis for awhile and if it works then it could be purchased.

HARRISON: So is the process, the service coordinator does the assessment and determines that it's needed and then the Waiver would pay for it?

PRIEST: The service coordinator would determine that there is a need for a device. The service coordinator would work with the family to identify providers and different devices, work with the provider potentially to allow use to make sure it's going to work or some sort of home demonstration of the product to see if it's appropriate and then if it was appropriate she could authorize it depending on the cost perhaps with some bids from like providers.

HARRISON: So all it would take was the service coordinator agreeing with the family that it's needed?

PRIEST: That's my understanding.

HARRISON: And you don't need a speech and language assessment?

PRIEST: Not according to the Waiver Manual or the Waiver document.

HARRISON: Okay. Can a Waiver participant choose which services she will get, he or she will get among those that are in the Waiver package?

PRIEST: Yes.

HARRISON: And what it takes to get that service in is the service coordinator doing an assessment and approving that service?

PRIEST: Typically the service coordinator would do the assessment and then the family and the service coordinator would determine the services that can meet that need and then if there's more than one service that is available to meet the need, the family and the person would have to make some decisions about which package of service would be most appropriate for that person. For example, if there's a limit of 28 hours per week on personal care and you feel that you need more than that then perhaps residential habilitation is the better way to meet the need or personal care, adult day health, and respite is a combination that's most appropriate. But that's a decision that's made by the person, the family, with the service coordinator.

HARRISON: But all it takes is the service coordinator and the family to agree that it's the need?

PRIEST: It is my understanding that that is correct. There's a need assessed by the service coordinator and then there are discussions with the family. The service coordinator assesses the need. The service coordinator and the family decide the feasible alternatives to address the need.

HARRISON: Has that process changed from prior to the amendments, the January 1st amendments, was that the same before?

PRIEST: No ma'am. Well, it's the only process I've ever known.

HARRISON: Okay. So, so were there any regulations previously about, about how that need is assessed? Are there any regulations about how that assessment takes place?

PRIEST: We have policies about how the assessment and we have instructions about the assessment tool.

HARRISON: So previously Ms. Myers and the service coordinator could agree that Al needed 80 hours a week?

PRIEST: It was supposed to be based on assessed need. It is supposed to be provided in accordance with the service definition.

HARRISON: And if the service coordinator assessed that, he would have been provided more than 28 previously?

PRIEST: That is correct.

HARRISON: And there's no regulations that have been implemented since then which would allow restrictions?

PRIEST: There is not—there is a Waiver document that includes the restrictions.

HARRISON: That's all I have for this witness.

SCHINDLER: All right. Redirect, Mr. Hepfer?

HEPFER: Nothing on redirect.

SCHINDLER: All right, then we're ready to move on to your next witness.

HEPFER: Thank you. Call Ms. Juanita A. Auker. Ms. Auker, would you please identify yourself for the people here?

AUKER: My name is Juanita Auker.

HEPFER: And what do you do?

AUKER: I'm a Service Coordinator for Kershaw County Board of Disabilities.

HEPFER: And tell us a little bit about your educational background.

AUKER: I have a Bachelor's Degree in Psychology and a Master's Degree in Counseling.

HEPFER: Okay. Are you a licensed counselor?

AUKER: No, I'm not.

HEPFER: Okay. You would still have to go through some supervision and take some tests in order to be a (unclear)?

AUKER: Yes.

HEPFER: Okay, but your degree is in Counseling?

AUKER: Yes sir.

HEPFER: And what is your—what are your duties as a Service Coordinator?

AUKER: Helping families connect with services that they need, assist as needed, monitor those services.

HEPFER: Okay. And are you familiar with Mr. Myers, Mr. Albert Myers?

AUKER: Yes.

HEPFER: And what's your—what's your relationship with Mr. Myers?

AUKER: I am his Service Coordinator.

HEPFER: How long have you been a Service Coordinator?

AUKER: With him since July of 2010.

HEPFER: Okay. And what services are currently—were, were authorized for Mr. Myers before he went into (Unclear) Nursing Facility?

AUKER: He received, right before he went in, he received Adult Day Health Care, Adult Day Health Nursing, Adult Day Health Transportation, PC—Personal Care Aide II services, Personal Care Aide I services, respite services, PT, medical services, dental/vision exam.

HEPFER: All right, what about—how many hours of Personal Care II services was he receiving?

AUKER: Personal Care II, 180 units a week. It was 45 hours a week.

HEPFER: 45 hours a week and how many hours of Personal Care I services?

AUKER: Six hours a week.

HEPFER: Okay. Would either of those services continue at their present quantity under the new Waiver?

AUKER: The PC I would continue as it is. Without the appeal, the PC II would not. It would be 28 units only.

HEPFER: It would be limited to 28 units?

AUKER: Yes.

HEPFER: Okay. What about respite services? Was he receiving any—how many hours of respite service?

AUKER: 101 hours a month.

HEPFER: Of respite service?

AUKER: Uh-huh.

HEPFER: And you divide that again by 4.3 to get the number of weekly hours, is that right?

AUKER: That's up to the family how they divided with the Agency but yes.

HEPFER: But if it was spread equally throughout the month...

AUKER: Yes.

HEPFER: ...you'd divide it by 4.3? All right. Could that continue under the Waiver?

AUKER: The 101 was modified at the time of the reduction but with an assessment, yes, it could continue because there is a limitation on—I mean an exceptance in that.

HEPFER: An exception to the limitations?

AUKER: Yes, to the 68 units.

HEPFER: Okay. All right.

AUKER: Yes.

HEPFER: And I think Ms. Priest read the criteria for that exception.

AUKER: Yes.

HEPFER: Okay. You understand that to be the exception, right?

AUKER: Yes.

HEPFER: Okay. So ADHC, tell us how that worked for Mr. Myers, Adult Day Health Care services.

AUKER: He switched from coming to our day center to Adult Day Health Care and that was just in the last few months he switched over from the day program to going to the Adult Day Health Care.

HEPFER: Now previously, what was the day program like?

AUKER: The day program, he came to our day program. He received—in the beginning he was receiving community services and day activity, half each day Monday through Friday.

HEPFER: How many hours total?

AUKER: Our program is from about 8:30 to 2:30.

HEPFER: Okay, and would he receive transportation to and from those services?

AUKER: Yes.

HEPFER: Okay and then it changed—those services were changed fairly recently to Adult Day Health Care services?

AUKER: To Adult Day Health, yes.

HEPFER: And how often would that be per day, how many hours a day?

AUKER: I believe it's similar to ours but anywhere from five to six hours a day.

HEPFER: Okay, and does he get transportation to and from?

AUKER: Yes, transportation was authorized.

HEPFER: And you don't know how long that would take?

AUKER: No, I know that they don't live that far from it but I don't know how long it...

HEPFER: You don't know whether he was the first one to be dropped off or the last one to be dropped off?

AUKER: No, I don't.

HEPFER: Okay. All right, would ADHC services be able to be continued under the new Waiver?

AUKER: Yes.

HEPFER: Okay. Does he—what about his noon day meal, how does that—how does that happen?

AUKER: He is tube fed and the Adult Day Health nursing was authorized to tube feed him while he was at the Adult Day Health Care.

HEPFER: Okay. You heard probably some testimony regarding also authorizing nursing services for other tube feedings, would that be possible?

AUKER: Under the Waiver from what I have read in the Waiver Manual, you cannot authorize Adult Day Health nursing and nursing services in the same day.

HEPFER: Okay. All right. So I guess the result of that is that a family member would have to feed him his other meals. Is that correct?

AUKER: Yes.

HEPFER: Okay. Thanks. Now he also received—did he receive psychological services prior to the, to the institution of the new Waiver?

AUKER: When the changes were made, no. That was recent. I believe it started in August of 2010 if I'm not mistaken.

HEPFER: And why were those authorized?

AUKER: When I talked with Ms. Myers she was talking about the loss of the main caregiver that had been in the home with him along with his grandmother I do believe and his father that had passed away, some grieving issues.

HEPFER: Some grieving issues?

AUKER: Yes.

HEPFER: Okay. And so that was authorized and his—was he still getting that at the time he went into the nursing facility?

AUKER: Yes he was.

HEPFER: Do you know how Mr. Myers services were apportioned during the day?

AUKER: Not for the most part. I know that when we authorize services we let the family talk with the agency because they know their needs, you know, their daily needs more than I do so they, you know, talk with them and see what, you know, when—what is needed, you know, when he changed and all of that kind of thing so we authorize a certain amount but it's usually up to the families and the agency to kind of work out you know when things are needed.

HEPFER: Okay. So for Mr. Myers—well, for most of your participants, do they get some services in the morning and in the afternoon?

AUKER: A lot of times, yes. They will go—maybe a Personal Care Aide would go in the morning to help them get ready if they attended either Adult Day Health or somewhere like the Kershaw Center. They would do that and then they would go to the center and then some get afternoon hours right when they get home, some, you know, not until it's time to go to bed maybe to get a bath, that kind of thing.

HEPFER: Okay. So 45 hours of PCA services per week, so roughly six hours per day if, if, if apportioned equally throughout the week, six hours a day.

AUKER: If it was done equally, yes.

HEPFER: Yeah, so let's say in an average case, three hours in the morning to get ready for care—get ready for the day, get changed, get bathed, get—have any toileting needs or grooming needs, three hours in the morning?

AUKER: Yes.

HEPFER: And then Mr. Myers, let's say would go to Adult Day Health Care for another five to six hours including transportation.

AUKER: Yes.

HEPFER: And then another say three hours in the afternoon for meal and preparation for bed and so forth.

AUKER: With him it wouldn't be for a meal but yes.

HEPFER: Oh, that's right...

AUKER: He's tube fed.

HEPFER: The respite care or the PCA provider would not be able to do the tube feeding.

AUKER: Yes.

HEPFER: And do you know who provided these services prior to I'll say April of this year?

AUKER: Prior to April?

HEPFER: Of this year. At one point was there a live-in?

AUKER: At one point there was a live-in person there that provided care and then I don't know you know how that was divided up but I know when I authorized.

HEPFER: And it was the same authorization that was—it continued?

AUKER: In place, yes, it continued.

HEPFER: As a result of the appeal, right?

AUKER: Uh-huh.

HEPFER: Okay, but those services would be cut back under the new Waiver?

AUKER: Yes.

HEPFER: Okay. All right. Specifically the Personal Care Aide service would be cut back and physical therapy would be discontinued, is that right?

AUKER: Yes it would.

HEPFER: And Mr. Myers was receiving physical therapy?

AUKER: Yes, and he continued to receive it.

HEPFER: You don't know about—or do you know about the availability of therapy under the State Plan?

AUKER: Under the State Plan I'm not aware. I did look online at the Medicaid/Medicare. From what I had read to my knowledge it was saying that it could be covered under Medicare but I don't know the restrictions on how it would be covered by Medicare.

HEPFER: Or and it could be covered under Medicaid also?

AUKER: Yes.

HEPFER: Okay, all right. At some point this year, was the live-in—did the live-in caregiver have to terminate services?

AUKER: I'm sorry?

HEPFER: There was a live-in caregiver at some point during this year?

AUKER: Yes.

HEPFER: At some point did that live-in arrangement stop?

AUKER: Yes. She, she was—she got hurt and was no longer living there.

HEPFER: Okay, all right. So services were provided by an Agency?

AUKER: Yes.

HEPFER: And what Agency was that?

AUKER: At the time that person was employed with our Agency and CarePro Medical if I'm not mistaken. And then that continued right afterwards and then we switched agencies. I want to say it was due to availability of caregivers is why we had changed but we—Ms. Myers decided to change agencies so we changed agencies and then we actually changed agencies again. We had some issues with the provider that we had and she decided to change again then. She was—we were at Nightingales and that's where we were until he went into the (Unclear) Home.

HEPFER: Okay, so there was some problems with reliability of caregivers?

AUKER: Uh-huh.

HEPFER: Okay and Ms. Myers (unclear)?

AUKER: She did and when she did we switched agencies.

HEPFER: Okay. And is it normal or is it a routine occurrence that providers will be out sick or have a flat tire or something like that?

AUKER: Yes, I mean anywhere, any job there's things that happen that people may be out of work so yes.

HEPFER: Okay. And that would have even happened maybe with the live-in caregiver, we don't know.

AUKER: Yeah, I don't know.

HEPFER: All right. Okay, now the live-in—how did the live-in caregiver, how did it happen that she stopped providing care?

AUKER: When she got hurt.

HEPFER: And how did she get hurt?

AUKER: I'm not sure how. I know that it was her hip but I can't state to what happened.

HEPFER: Okay. There was a lift in the home, was there not?

AUKER: There was a lift. It was a Hoyer lift I believe. I'm not sure. I know it was an older, an older lift.

HEPFER: Okay. And did you have that replaced?

AUKER: We did. That was one of the main issues and we discussed that and we had the lift put in in the bedroom and the bathroom. When we first did it, the motor that mainly works the lift, it was very, very heavy. I did it myself. Ms. Myers called me over there and I had to monitor it anyway so when I lifted it up and she had to carry it from the bedroom to the bathroom, there was a track in both but the track would not run all the way to the bathroom. They were unable to do that so but what we were able to do is we were able to get a motor that ran the whole lift for the bedroom and the bathroom so that she wouldn't have to pick that up and take it from one to the other because it was very heavy and hard to do.

HEPFER: And what is a lift used for?

AUKER: To help the mother or the caregiver and the agencies as well, the people coming in to lift the person from the wheelchair to the bed, from the bed to the wheelchair, from the wheelchair to the bathtub, those kind of things.

HEPFER: Okay, does a lift also assist Mr. Myers with getting from the wheelchair to the commode?

AUKER: No, because he wears diapers.

HEPFER: All the time.

AUKER: So he doesn't use the commode.

HEPFER: All right. And is the—the lift, is it designed to be operated by one person?

AUKER: I mean when I was in there Ms. Myers was in there and the caregiver. I can't remember if it was PCA or respite at the time. Both of them were standing there but you take the sling and you hook it, you hook it to the lift. There's four things on—I mean one thing on—I'm sorry, two on this side and two on this side and you put the sling and you hook it to the lift...

VOICE: Straps.

AUKER: ...straps, there you go.

HEPFER: And the person is in the sling?

AUKER: In the sling, yes.

HEPFER: But what...

AUKER: And then you use the remote control to move the lift across and lowered and (unclear).

HEPFER: Okay, and is it the kind of thing that if a person flailed around or his limbs were not in control, could the person fall out of the sling?

AUKER: Not that I'm aware of, no. I have other families that one person operates the lift. They have the same exact lift and one person does it.

HEPFER: The sling goes all around the person?

AUKER: All the way around the person, yes.

HEPFER: Okay. And the track, is it a circular track or is it a one way track?

AUKER: Just a one way track.

HEPFER: Just forward and back?

AUKER: Yes.

HEPFER: All right. All right, Mr. Myers also had a Medicaid card, is that right?

AUKER: Yes.

HEPFER: So he would be able to receive State Plan services like dental services, medical services.

AUKER: Dental was through the Waiver.

HEPFER: Oh dental was through the Waiver, I'm sorry.

AUKER: Adult dental was through the waiver and adult vision, the exam. He did not wear glasses but they switched from the exams being covered under

Medicaid, State Plan Medicaid to being covered under the Waiver so that was one of the services we applied for that exams to be under the Waiver.

HEPFER: Okay. And did Mr. Myers ever use his speech therapy authorization, do you know?

AUKER: We had never authorized it. We had talked about it several times. I know the last time I had talked with Ms. Myers she was working with Lennie Mullis because Lennie knew somebody that could possibly get the kind of device Ms. Myers was looking for. Ms. Myers—they kind of knew what kind of device they were looking for and so she said that Ms. Mullis was helping with her to—I think they had already located a person but they were looking at a certain kind of device.

HEPFER: Would have had to authorize the speech therapy or evaluate him?

AUKER: The evaluation, yes. They were more looking for the actual device. In the beginning I thought it was more for an evaluation but she needed the device.

HEPFER: Okay, she thought she needed a device. Okay.

AUKER: Yeah, the device to actually help him.

HEPFER: Okay. Can you think of any other services that would have been available within the Waiver that might have been appropriate for Mr. Myers?

AUKER: I can't think of any that he wasn't already receiving.

HEPFER: Okay. Okay. Under your authorization, it doesn't authorize 24 hours of care, does it?

AUKER: No, it does not.

HEPFER: And so Ms. Myers would be expected to provide some of the care under your authorization under the Waiver, right?

AUKER: Yes sir, all of our families are.

HEPFER: Do you have any other people that are similar to Mr. Myers that are receiving services?

AUKER: I do.

HEPFER: And how many hours of care are they receiving?

AUKER: They are receiving the—some at the limits and some under the limits of what the Waiver...

HEPFER: The new Waiver.

AUKER: ...the new Waiver provides.

HEPFER: Okay. Okay. Thank you very much. Ms. Auker, please answer any questions Ms. Harrison has.

HARRISON: Thank you, Mr. Hepfer. As service coordinator can you exceed the number, the 28 hours of PCA services if you feel like Al needs additional services?

AUKER: PCA II hours, no.

HARRISON: What about the—could you exceed the adult companion services if he needed those?

AUKER: No.

HARRISON: Okay, could you, could you provide additional—could you provide—could you authorize speech therapy now?

AUKER: Under the new waiver, no.

HARRISON: Could you authorize physical therapy?

AUKER: Under the new provisions, no.

HARRISON: Okay. Under the new provisions, how would he get speech therapy?

AUKER: Well, as I stated before I'm not completely familiar with State Medicaid and the Medicare but when I was looking under it I don't know what the restrictions are but it said that some of the PT, OT, and Speech could possibly be provided under there but I do not know the restrictions.

HARRISON: Okay, are you not the service coordinator for all the services he needs?

AUKER: For all of the services he needs. Usually what I do is I tell families to talk with their doctor about PT and OT and Speech and they can help them if Medicaid will cover it.

HARRISON: Okay, so what are the criteria, does he not have to require hospitalization now to get it?

HEPFER: She just testified she didn't know what the criteria are.

HARRISON: Tell me what a service coordinator does. What's, what's the role of a ser—what are the duties of a service coordinator?

AUKER: To assess needs, to help connect families with the services that they need, to monitor those services.

HARRISON: And do you only connect them with Waiver services?

AUKER: No, services in the community as well.

HARRISON: Okay. And the Board gets a set rate every month for the service coordination services, do they not?

AUKER: Yes.

HARRISON: Okay. And what kind of training did you get when these new restrictions were put into place?

AUKER: Well, every year we have a certain amount of training that we have to go to whether it's restrictions on the Waiver, changes in the Waiver, changes with our plans, assessments, we have to go training for all about it.

HARRISON: Did they train you since they were reducing those services through the Waiver, did they train you about how to access the services outside of the Waiver?

AUKER: I'm not sure if that...

HARRISON: PT, OT and Speech.

AUKER: Okay. Not necessarily a training on how to access those services but we are always trained to look in the community elsewhere on how things can be provided.

HARRISON: So you don't know what the criteria is now for PT, OT and Speech.

AUKER: No.

HARRISON: You don't know what they have to show.

AUKER: For, no, not for Medicaid or Medicare to pay for it.

HARRISON: Okay. If, if Al's mother went in the hospital for six months, would the services under the new Waiver be sufficient for him to stay at home?

AUKER: To stay at home if she was in the hospital?

HARRISON: Right.

AUKER: Not to stay at home. We could possibly do institutional respite.

HARRISON: Okay, but that would require him to go to an institution.

AUKER: Yes.

HARRISON: Okay. But the services would not be sufficient absent the resources of the parents?

AUKER: Not to be at home at all, no.

HARRISON: Okay. Now, the ADHC issue, did Ms. Myers request nursing services?

AUKER: For the Adult Day Health Care?

HARRISON: No. Did she request nursing services to feed him at home?

AUKER: Yes.

HARRISON: And were those services provided?

AUKER: No.

HARRISON: And why were those services not provided?

AUKER: When I had looked at the regulations for nursing services they could not be provided while he was attending the Adult Day Health Care and during the week he could not be attending the Adult Day Health Care and get nursing services at the same time.

HARRISON: These were regulations?

AUKER: Yes.

HARRISON: Can you cite me the regula—were these policies or regulations?

AUKER: They were in the MR/RD Manual.

HARRISON: Okay, so is that...

AUKER: When you look at the chapter with nursing services.

HARRISON: Had those been promulgated as regulations?

HEPFER: Madam Hearing Officer, she doesn't know the answer to that.

HARRISON: Well, she testified that that they were regulations.

HEPFER: Well, yes, and...

HARRISON: And I'm trying to clarify there are no regulations.

HEPFER: Okay. All right, I'm sorry. I withdraw my objection. Go ahead and clarify.

HARRISON: I mean would you want to agree that there are no regulations?

HEPFER: Go ahead and ask her the question.

HARRISON: Because she's testified that there are.

HEPFER: Yeah, clearly she did. Go ahead and clarify.

HARRISON: Are there regulations or are those policies?

AUKER: Policies. It's in the Manual chapter.

HARRISON: Okay, but those aren't regulations?

AUKER: No.

HARRISON: Okay. So Ms. Myers asked for nursing services to provide feeding at home and they were turned down because of the DSN policy that is not a regulation, is that correct?

AUKER: Yes, they were turned down because you cannot receive both services, yes.

HARRISON: Okay, what about on the weekends, was she provided nursing services on the weekends when she didn't go—when he didn't go to the Adult Day?

AUKER: No.

HARRISON: Okay, do those policies prohibit that?

AUKER: No.

HARRISON: Okay, did the doctor order nursing services on the weekend?

AUKER: He didn't order services, no.

HARRISON: Okay, was there not a letter that said he needed nursing services?

AUKER: There was a letter.

HARRISON: Did it say that he needed nursing ser—additional services on the weekend?

AUKER: It did.

HARRISON: And were those provided?

AUKER: No, they were not.

HARRISON: Okay. How did you determine that Al only needed 110 hours of respite?

AUKER: 110?

HARRISON: Was it—how many hours of respite?

AUKER: 101 hours of respite a month.

HARRISON: 101 hours of respite. How did you determine that?

AUKER: I did not determine that. Before—before I got the case that's what it was. When the changes were being made the information, Brandy was the service coordinator, and she did the assessment and sent it into DDSN and DDSN sent it back down and it was determined that he would receive 101 hours so I did not have the case but it was based on an assessment.

HARRISON: What is the cap on the number of hours of respite a person can receive under the new rule?

AUKER: Under the new one it's 68 hours a month and then there's an exception to I believe it's 240, I believe.

HARRISON: So you could receive up to 240 under the new waiver.

AUKER: If you do the exception, yes.

HARRISON: Okay. So based on what you know about Al, he was capped at 28 hours a week, help me, walk me through, if, if Ms. Myers was not able to provide care, how would the services under the new waiver meet his needs?

AUKER: If she wasn't able to provide any care?

HARRISON: Right.

AUKER: Under the Waiver if she's not able to provide any care, then it wouldn't in the home.

HARRISON: So it's not sufficient absent the parental resources?

AUKER: If the parent is not home to provide any care at all, no. It is to supplement.

HARRISON: And is that in a regulation somewhere that says it's to supplement?

AUKER: It's in something, I'm not sure if it's a policy or what it's in but yes, it is written somewhere.

HARRISON: Are you aware of any regulations on the administration of the Waiver?

AUKER: Can you repeat that?

HARRISON: Are you aware of any regulations that have been promulgated by the Legisature, regulations, State regulations?

AUKER: No.

HARRISON: Okay. How do you determine medical necessity?

AUKER: As far as?

HARRISON: The medical need for a service?

AUKER: I don't necessarily determine medical need. We go by our assessment and assess the needs that are there.

HARRISON: And how do you do that assessment?

AUKER: By talking with the family, medical information, if they go to the Adult Day Health, you know, discussing that with them, the day program, if they attend the day program, we get information from all parties.

HARRISON: Do you have any medical training?

AUKER: No, I do not.

HARRISON: Okay. So how many times have you talked to Al's physician about the services he needs?

AUKER: I don't talk to him. I get doctor information.

HARRISON: What doctor information have you...

AUKER: Like his doctor visits, if there's been any new assessments or anything like that then we update the file with that information.

HARRISON: Did you get the letter from his physician, I need to find it...

VOICE: That one?

HARRISON: Yes, did you get that letter from his physician?

AUKER: Yes, I did.

HARRISON: Okay. And how many hours did his physician determine that he needs?

AUKER: Of?

HARRISON: How many hours of nursing services did his physician determine that he needs?

AUKER: Two hours of nursing and it's a total of six hours, let's see, because it's six hours during the week and eight hours on the weekends. Is that what...

HARRISON: Well, what does the letter say?

AUKER: On Saturdays—on Saturdays and Sundays, any day Al isn't able to attend the Kershaw DSN Program he requires eight hours of nursing services in addition to sixteen hours a day of PCA II services.

HARRISON: And how many nursing hours did his physician determine he needs a day when he's going to the ADHC.

AUKER: Six hours I believe. Let's see, two hours and two hours and two hours would be six hours.

HARRISON: Okay, did you talk to the physician about why the physician felt that he needed that many hours?

AUKER: No, I did not.

HARRISON: Okay, did you—you're saying that on the days—the policy prohibits him from getting nursing on the days he goes to ADHC?

AUKER: Yes.

HARRISON: Okay. Why were the hours not provided on the weekends on the days he doesn't?

AUKER: The other medical information we received from the doctor other than the letter did not show an increase in medical need. There was no changes in his health. By me saying that, there was no changes in his health, all along he has not received nursing services so with there being no changes in his health, it did not need to be authorized.

HARRISON: Okay. If he had previously not been receiving cholesterol medicine and he'd had high cholesterol for years but it hadn't been treated, would you deny payment for cholesterol medication because he didn't receive it before?

AUKER: I can't answer that.

HARRISON: Well, if somebody needed—had a—a doctor presented a prescription for cholesterol medication, do you look to see whether he was taking it before to determine whether or not to provide it?

AUKER: I don't have anything to do with medication or providing medication.

HARRISON: Don't you approve payment for the prescription?

AUKER: No, I do not.

HARRISON: Okay. Okay, so you're saying—can you show me the medical records that you relied upon in determining he didn't need those hours?

AUKER: I believe this is—without looking further I think this is it.

HARRISON: Okay, tell me—read the part of the physician's records that outlaid this order.

AUKER: Which outlaid, I'm sorry?

HARRISON: That, that carried more weight than this order saying that this is how many hours he needs.

AUKER: There was nothing particular that weighed more than anything else. With talking with his mother, with talking with day program staff, with talking with—with looking at medical records, looking at everything together, there was no, no increase in medical needs. Nothing had changed medically with him. He was not receiving nursing before. No medical needs had changed so there was no need to add nursing.

HARRISON: Because he hadn't received it before. That's the standard, you had to have been receiving it before to get it...

AUKER: You don't have to receive it before but there was no changes to, to warrant it needed.

HARRISON: Did he need two hours—did he need—do you allow a PCA to help with his feeding?

AUKER: No.

HARRISON: Okay, did he need to be fed in the mornings?

AUKER: Yes he did.

HARRISON: Did he need to be fed in the afternoon?

AUKER: Yes.

HARRISON: Did he need to fed in the evening?

AUKER: Yes.

HARRISON: Okay. And did the doctor say that he needed nursing services for those two feedings?

AUKER: Yes.

HARRISON: So, please show me the medical records that you considered to—that you gave deference to instead of this letter.

AUKER: I didn't give deference to anything. Not only can a nurse provide that but family members can provide the tube feedings.

HARRISON: But, but is a family obligated to do that?

AUKER: They're not obligated, no.

HARRISON: Okay, would you be considering the resources of the family if you denied nursing because a parent could do it?

AUKER: I'm sorry, can you...

HARRISON: Are you considering the resources the parent brings to the table in making that decision?

HEPFER: I don't think she understands the question. Can you try to rephrase it?

HARRISON: Al's mother has been a resource to him, has she not?

AUKER: Yes.

HARRISON: Okay, are you considering the resource of his mother in determining whether or not to comply with the doctor's order?

AUKER: It's not that I didn't comply with the doctor's order, but you will get the whole picture. When you're deciding services and what a person needs you look at the whole picture and what they need.

HARRISON: Okay, and tell me, you said you looked at medical records, tell—would you please read from those medical records the sections that you relied upon that outweighed this letter.

HEPFER: Well, I think that's the third time you asked the question and she said she didn't rely on specific parts of it. She looked at the whole picture.

HARRISON: Okay, if we can get a copy of the medical records she relied upon.

HEPFER: I don't have any objection to that part of the record.

SCHINDLER: All right.

AUKER: And it was the whole picture. It was everything. It wasn't just one particular thing.

SCHINDLER: Ms. Lewis will make copies for us. Thank you, Ms. Lewis. Ms. Harrsion, you want to wait until we get the copies?

HARRISON: Fine.

SCHINDLER: All right. We'll go off the record for a moment. Back on the record. I just received a copy of Mr. Myers medical record from Dr. Munn and I'm going to call this Respondent's Exhibit 7.

HARRISON: Okay, these are the medical records you relied upon?

AUKER: Yes.

SCHINDLER: Excuse me. Ms. Harrison, I actually misspoke. I'm calling this Petitioner's Exhibit 7. Please proceed. I'm sorry about that interruption.

HARRISON: Okay. Would you list each factor you relied upon in making the decision that he didn't need those nursing hours?

AUKER: Without looking directly, I mean usually what we do if I can just speak from what we usually do is we gather information, looking at all of the information, talking with Ms. Myers, talking with the parent, medical information and look at that information and what we—what we gather through the year for the person.

HARRISON: Okay, so talking to Ms. Myers she was telling you she needed those hours, was she not?

AUKER: Yes.

HARRISON: Okay, what did she say that you relied on to make that decision?

AUKER: I can't remember directly what she said to make the decision.

HARRISON: Okay, and isn't it true that you relied on her to provide the nursing services that were ordered by the physician?

AUKER: (Unclear) yes.

HARRISON: Okay, and how did you determine that this need would be met without providing nursing services?

AUKER: With the parent.

HARRISON: Okay, but the parent was saying she needed them.

AUKER: Right.

HARRISON: Okay, and the medical records show that he had a history of aspiration and pneumonia, is that correct?

AUKER: Yes.

HARRISON: Okay, and the medical records show that he had a history of a pressure sore?

AUKER: Yes.

HARRISON: Okay. Is there anywhere in the medical record that it says that he doesn't need the number of hours that were requested for tube feeding?

AUKER: No.

HARRISON: Okay. What would happen to Al absent Ms. Myers providing the tube feeding? If she didn't do that nursing service, if she said I'm not a nurse, I'm not going to do that? What would happen to Al if he stayed at home?

AUKER: If she wouldn't do the tube feeding at all then I guess institution, being placed in an institution.

HARRISON: What if he refused to go to an institution, what would happen to him?

AUKER: I don't know.

HARRISON: Would it affect his health if he didn't get the tube feeding?

AUKER: Of course.

HARRISON: Okay, did you make an assessment as to whether or not Al needs psychological services?

AUKER: When we did the plan meeting we discussed that need and that need was put on the plan.

HARRISON: And did you determine that was a need that Al had?

AUKER: Yes, for psychological service.

HARRISON: Okay. Why did you feel that he needed that need?

AUKER: From the assessment that we did, we discussed his bereavement and we went from there.

HARRISON: Has that changed?

AUKER: That he needed the service?

HARRISON: Right.

AUKER: No.

HARRISON: Okay, and is the transition to an institution—tell me what's happened to Al since we filed the request for this—for the nursing services.

AUKER: Since you filed the request?

HARRISON: Since we provided the Board this letter saying that he needed those nursing services.

AUKER: I know that he's now at the (Unclear).

HARRISON: But please explain for the record what (Unclear) is.

AUKER: A nursing home.

HARRISON: Okay. Is he—are there other people his age there?

AUKER: Do be honest with you, I don't know all of the ages of somebody in a nursing home.

HARRISON: Have you seen any—do you ever go there?

AUKER: I mean—yes, I have been there before.

HARRISON: Have you ever seen anyone as young as he there?

AUKER: Not that I recall but I—I don't know all the patients there.

HARRISON: Tell me about Al, is he able to comprehend things? Does he understand his surroundings? Does he laugh at your jokes?

AUKER: Yes.

HARRISON: Okay. What is your assessment of what kind of socialization he needs?

AUKER: I'm not sure exactly.

HARRISON: Do you think he has a need for socialization?

AUKER: I think we all have a need for socialization, even if you're not aware of your surroundings I think everybody needs socialization.

HARRISON: Does the fact that he's aware of his surroundings make his need for socialization greater?

AUKER: My opinion, no, because I think that everybody whether you're aware of it or not needs socialization.

HARRISON: Is this transition for Al a, a difficult transition to make from the home he's lived in for many years into an institution?

AUKER: I think that any transition would be difficult. There's an adjustment period I would think for anybody in any situation like that.

HARRISON: Okay. As a service coordinator, you're required to—service coordination is not a waiver service, is it?

AUKER: Service coordination, no.

HARRISON: Okay, so that's not affected by whether he qualifies for the waiver or not?

AUKER: I'm sorry.

HARRISON: People get service—they continue to get service coordination even when their...

AUKER: Yes.

HARRISON: ...waiver services are terminated, right?

AUKER: Yes.

HARRISON: Okay, as his service coordinator, what have you done to assure that he continues to get psychological services?

AUKER: Well, once the—once you enter a nursing home, you cannot get psychological services. I'm not sure if that's something provided possibly by the nursing home. Ms. Myers has not spoke to me about still needing psychological services.

HARRISON: Okay, but, but you would agree that he continues to have that need. Did his need go away because he went to a nursing home?

AUKER: I wouldn't think that his need would go away, no.

HARRISON: Okay. As his service coordinator you're still—your duties is still to find the services that he needs, is it not?

AUKER: Yes.

HARRISON: Okay. Have you—have you looked at what specialized services—were you consulted when DDSN determined what specialized services he would need in the nursing home?

AUKER: In a nursing home, no. An assessment was done—an assessment was done by Community Long Term Care if I'm not mistaken.

HARRISON: Are you aware that someone from DDSN made an assessment to determine whether or not Al continued to need specialized services? Did anyone from DDSN call you and say hey, I'm doing this evaluation, what does he need?

AUKER: Before he went into the nursing home?

HARRISON: Right.

AUKER: No.

HARRISON: So nobody from DDSN contacted you, the service coordinator, to determine whether he, he continued to need what Medicaid calls specialized services?

AUKER: No.

HARRISON: Okay. Are you familiar with specialized services, the term specialized services?

AUKER: The term, no, I'm not.

HARRISON: Okay, but it—but, but your job included assessing all services not just DDSN services.

AUKER: Yes.

HARRISON: Okay. But no one from DDSN contacted you?

AUKER: About him going into a nursing…

HARRISON: About what he might need in a nursing home?

AUKER: No.

HARRISON: Okay, and how long have you worked with Al?

AUKER: Since July of 2010.

HARRISON: Okay, so do you feel like you're pretty familiar with his needs?

AUKER: I would say so.

HARRISON: Okay. But no one from DDSN contacted you?

AUKER: No.

HARRISON: Are you familiar with PASRR?

AUKER: No.

HARRISON: Okay, the PT evaluation. You've had a chance to look at that?

AUKER: Yes.

HARRISON: Do you disagree with the assessment of this PhD physical therapist that during the few weeks he didn't have PT he developed painful contractures?

AUKER: I mean all I can go by is what they say.

HARRISON: Do you have any reason to disagree with that?

AUKER: No.

HARRISON: Okay. Are you familiar with Al's contractures?

AUKER: Yes.

HARRISON: And tell me about those.

AUKER: I mean I know that he has the muscle contractions, I mean I'm not—I've never worked on him, you know, with him one on one but I do know that his muscles contract and that that's one of the reasons why he gets the physical therapy.

HARRISON: Okay, are they painful, contractures?

AUKER: That I don't know.

HARRISON: Okay, is the notice and we'd like submit that it's a Plaintiff's Exhibit.

SCHINDLER: All right, Mr. Hepfer, do you have any objection to this being admitted to the record?

HEPFER: No, I don't. It's a letter from DDSN apparently to the recipients, participants and their families.

SCHINDLER: All right.

HARRISON: Is that the notice that was sent out?

SCHINDLER: Hang on a second, Ms. Harrison. I'm going to call this Petitioner's Exhibit Number 8. It's a letter dated December 1, 2009 from DDSN. Okay, go ahead. Sorry about that.

HARRISON: Is that the—is that the notice that was sent out to Al?

AUKER: I believe it was, yes.

HARRISON: Okay. Does it say anything about Al's particular needs?

AUKER: No.

HARRISON: Was it—is there—do you have any evidence in your file that he even received this notice?

AUKER: I would have to look back. That was before I had the case so.

HARRISON: Do you have that—I guess you could look during that period of time.

AUKER: And if it was—I'm not sure if it was sent by DDSN. If it was sent by DDSN, the main office, then I wouldn't have—I wouldn't have anything in the file.

HARRISON: But that is the notice that was sent out?

AUKER: Yes.

HARRISON: Okay. What was the reason given for reducing services?

AUKER: I'm trying to remember back. When all of that was going on I know that they were looking at services and...

HARRISON: Well, what's the reason on the notice? The notice, the notice has to contain a reason for changing services, doesn't it? What is the reason given in the notice?

AUKER: I'm sorry. I'm not reading where the—I see the limitations. I'm not sure if I'm missing where the...

HEPFER: Madam Hearing Officer, the notice is a written document and it can speak for itself.

HARRISON: Okay, but the Regulations says the notice has to contain the reason for the reduction, the Federal Regulation and I can pull that section, requires that the notice, so I think it's very relevant, Your Honor, that whether—when the service coordinator whose job it is to—they tell you get in touch with your service coordinator, it's very relevant what someone who's a professional believes the reason is because the—and then that gets into, Your Honor...

HEPFER: Well Madam Hearing Officer, there may have been a—that may could have been an issue in the original appeal of this matter that was held sometime ago but we're way past that now. We've already had that original case that was dismissed. The matter has gone to an Administrative Law Court. By now everyone here knows the reductions and limitations that have been made and everyone knows several reasons why the Department has said that those reductions should be made but I mean we're way past the issue of notice now.

HARRISON: Your Honor, with all due respect 431.210 contains very specific requirements for a content of notice. It says the notice must contain the reasons for the intended action, the specific regulations that support...

SCHINDLER: Ms. Harrison, I'm familiar with that part of the CFR and since we have the actual notice in the record, I can evaluate that so you can proceed with your questioning.

HARRISON: My point is that in order to prepare for these hearings, you need to know what the reason is.

SCHINDLER: Yes.

HARRISON: But if you don't know the reason and when you're ambushed at the hearing with a different reason, then that affects Al Myers' ability to prepare for this hearing and when it's not corrected this time, the next time

Al Myers comes here and there's a defective notice, my issue is that this is something that is subject to repetition yet it has not been, and for us to carry this on up, we need to get this on the record that for many years, time after time after time, Hearing Officers have said the notice was defective and she's still, she's still in that loop. If, if, if she is dissatisfied with the decision here, she'll go on up and if we don't preserve this evidence and the fact that the service coordinator reads the notice and can't tell me what the reason is, is very relevant when Ms. Myers if she needs to go on up, that the content of the notice was defective thereby denying his due process. Because we've come to this hearing today with a notice that these are the reasons and even a professional can't determine the reason and then we have a witness from DDSN tell us it was something totally different was the reason. The reason was that PT definition has changed and that's not in this notice. So it affects Al Myers' ability to, to prepare for a hearing today and then if this entity doesn't correct that, the next time he has to come—this is the second or third appeal Al Myers has had in about a year. So if this problem isn't corrected, then it continues and this Agency has...

SCHINDLER: Please proceed with your questioning. That's fine.

HARRISON: Okay. So you can't—isn't it true that you can't tell what the reason is?

AUKER: By (unclear)?

HARRISON: Okay. Would you please cite for me from that notice the specific regulations that support or the change in Federal or State law that requires the action?

AUKER: I mean it basically just tells the—what the limitations are.

HARRISON: Okay, but where's the regulation or law in that notice?

AUKER: If I'm not mistaken, there's not one.

HARRISON: Okay, thank you. Have Al's personal care needs diminished in the last two years? His needs?

AUKER: In the last two years, I'm not sure since I've had the case. From my knowledge they have stayed about the same. I mean what he could do

when I received the case to what he can do now is about the same. I mean he wasn't able to use the bathroom. He was tube fed. All of that has stayed the same.

HARRISON: Okay, but with these changes you've put additional burdens on mom to cover those PCA hours that were provided, is that not correct?

AUKER: During the appeal she has still received those hours.

HARRISON: But, but when those are gone, that will be on her.

AUKER: Yes.

HARRISON: Okay, and the fact that she's doing those, does that not increase her need for nursing because she's providing additional hours when those go away?

AUKER: Possibly.

HARRISON: That's all I have, Your Honor.

SCHINDLER: All right, Mr. Hepfer, do you have any redirect?

HEPFER: Yeah, just a couple of questions. Even with receiving ADHC services during the week, Mr. Myers could be authorized to have nursing services on the weekends?

AUKER: Could, yes.

HEPFER: Okay. Do you normally get a copy or participate in the CLTC assessment before the person goes into a nursing home?

AUKER: This is the first time since I've been there that I've had somebody enter in the nursing home.

HEPFER: And you didn't get a copy or anything like that?

AUKER: I did not. I did not know he was going in until the Thursday before the Monday that he was going in.

HEPFER: Okay. Do you know whether Mr. Myers got a different specific notice than the general notice that you've been given?

AUKER: Not that I'm aware of. I did not have the case then so I was not the service coordinator. To my knowledge, this is what they got but I know that at that point, the service coordinators talked to the families to discuss the services and the changes.

HEPFER: Okay. Do you think Ms. Myers has been made aware of the limitations of the waiver?

AUKER: Yes.

HEPFER: Okay. Thank you. That's all I have.

HARRISON: So you're saying that she could have gotten—she was entitled to get nursing on the weekend?

AUKER: With the—with the waiver services, it's a possibility that you can get it on the weekends. As I stated before when we had looked at it, there had been no changes in his health and so that's why it wasn't authorized at the present time.

HARRISON: Okay, now I believe did the doctor also talk about and maybe I'm—that when he's not receiving—able to attend the DS—the day program, whatever day program he's in, did the doctor not order nursing, additional nursing hours for those days?

AUKER: The doctor had said he needed it, yes.

HARRISON: Like when the Adult Day Health or the day program isn't open?

AUKER: Yes.

HARRISON: Did you provide those within 90 days of the request?

AUKER: Provide the nursing services?

HARRISON: Right.

AUKER: No, because when we done the—when we looked at everything it wasn't—we didn't authorize it.

HARRISON: Who did you talk with about whether it should be authorized?

AUKER: I looked at all of the information and I reviewed it with Ms. Warren.

HARRISON: With the Director of the DSN Board?

AUKER: Yes.

HARRISON: Did you consult any regulations?

AUKER: As to?

HARRISON: Did you consider Al's mother's increasing age and her physical limitations?

AUKER: We always look at the caregiver and their age and all that, yes ma'am.

HARRISON: Has that changed since January 2010?

AUKER: I know that we've discussed her health and the different things that has been going on. I know that it hasn't decreased a lot but I know that she said that she does have some health problems.

HARRISON: Hasn't she had back problems?

AUKER: From what she has told me, yes ma'am.

HARRISON: And I believe heart problems?

AUKER: That I'm not aware of.

HARRISON: Okay. And, and there has been an increase in those problems, hasn't there?

AUKER: I'm not sure that—I'm trying to figure out how to answer that. I know that she has told me about her health problems but I can't answer if there has been an increase.

HARRISON: Okay, would that affect her ability to provide services in the home?

AUKER: If there's an increase in the family member's ability, yes.

HARRISON: You mean if there's a decrease.

AUKER: Yeah, I'm sorry, yes.

HARRISON: Okay, and under the—it seems like under the criteria you were using where they didn't need it before and there's been no change in his condition, a parent aging, how does that affect that factor?

AUKER: Well, like I said before, everything is looked at, the whole picture is looked at. And everything is taken into consideration.

HARRISON: And how much weight did you give to her health and her mental health and her physical health in deciding he would not be given the nursing services that the Waiver would allow him to receive?

AUKER: Again, I'm not sure if I put more weight on one thing or another. Just gathering all of the information and looking at it.

HARRISON: And what weight did the doctor's order carry?

AUKER: Again, like I said, I looked at all of the information.

HARRISON: Did it carry more weight?

AUKER: I wouldn't say that anything carried more weight than the other.

HARRISON: Okay, but you would agree that as someone's health declines and as that person ages, there's going to be more need for services in the home, would you not?

AUKER: I would think so, yes.

HARRISON: Okay, I have nothing else for this witness.

HEPFER: Yeah, and I'm sorry this goes back to cross—your cross-examination if you'll allow me to ask one more question.

SCHINDLER: Of course.

HEPFER: You talked about institutionalization, do you know whether—and you also probably heard Ms. Priest talk about habilitation services, that would be like a structured living program I and II, CTH I and II. Do you know whether those are institutions or community services?

AUKER: Institutions.

HEPFER: You think they're institutions?

AUKER: Yes.

HEPFER: Okay, thank you.

HARRISON: We have no more.

HEPFER: Okay.

SCHINDLER: Well, we're going to take a break. It is—we are on the record. Mr. Hepfer, would you like to call your next witness?

HEPFER: I would like to call Ms. Lewis and Ms. Lewis has not been sworn in I don't believe.

SCHINDLER: Oh, I'm sorry. And Ms. Mullis isn't here so I guess we can't swear her right now. Do you swear that the testimony you are about to give is the truth?

LEWIS: Kara Lewis, I do.

SCHINDLER: Without choking? (Laughing).

HEPFER: Ms. Lewis, what do you do for the Agency?

LEWIS: I work within Community Long Term Care as a Waiver Coordinator for two of the programs, specifically the MR Program and the Community Supports Waiver.

HEPFER: Okay. So you're familiar with the Waiver?

LEWIS: Correct.

HEPFER: Okay. What is—is the Waiver, I guess is, you've heard it described as a set of services that prevents institutionalization?

LEWIS: Correct.

HEPFER: And is habilitation services one of the waiver services?

LEWIS: It is.

HEPFER: And is that considered a community service or an institutional service?

LEWIS: It's a community service. It is one of the Waiver services.

HEPFER: The service coordinator testified that it was an institutional service.

LEWIS: She did. I think she just misspoke.

HEPFER: All right. Okay, thank you. I have no other questions of Ms. Lewis.

HARRISON: Okay, can a person get residential habilitation if they live in a home with their parent?

LEWIS: No.

HARRISON: So Al would have to go to—are you familiar with Al?

LEWIS: No.

HARRISON: A person who has a feeding tube and requires 24/7 attention, would he have to go to a congregate setting to get residential habilitation?

LEWIS: He could get residential habilitation at one of the CTH settings, yes.

HARRISON: But that's a congregate setting, isn't it?

LEWIS: It is.

HARRISON: So he couldn't stay in his own home and get that service?

LEWIS: That's correct.

HARRISON: Okay, let me ask you something. Are you familiar with the State Medicaid Plan?

LEWIS: I have seen parts of it over a time.

HARRISON: Could you look at this part of it. It's page 1 out of 31. I'm not sure which exhibit this is. It's got the definition of specialized services.

SCHINDLER: Okay, it's I think Petitioner's Exhibit 3.

HARRISON: Okay, can you tell me what this page is from?

LEWIS: Well, the title of it reads, State Plan Under Title 19 of the Social Security Act.

HARRISON: Okay, and this deals, does it not, with mental—people who have mental illness and mental retardation?

LEWIS: It goes on to say State/Territory South Carolina, definition of specialized services and then under that it reads, For mental illness, specialized services for those services which combined with blah, blah, blah and then it goes on and describes what I presume are specialized services therein.

HARRISON: Okay.

HEPFER: Madam Hearing Officer, is this cross-examination of what I asked Ms. Lewis about?

HARRISON: It's my direct I thought.

SCHINDLER: This is your cross of Mr. Hepfer's witness.

HARRISON: But I'm not limited to what you asked about.

HEPFER: Well...

HARRISON: I haven't had a shot at her yet. You can't put somebody up and just ask what you want to and let them go.

HEPFER: Well, I thought cross-examination was for the purpose of questioning direct examination.

HARRISON: You can't put somebody up and ask them one question and limit me once that witness is on the stand to what you asked about.

SCHINDLER: Please proceed.

HARRISON: Okay. It's true, is it not, that when a person with mental retardation goes into an institutional setting, there has to be a PASRR evaluation, is that not true?

LEWIS: PASRR is not anything that I deal with but my understanding is that is correct.

HARRISON: Okay. And what's the purpose of PASRR?

LEWIS: My limited understanding of PASRR as I just explained is that that's not my expertise but my limited understanding is to determine if there's a presence of mental illness.

HARRISON: Or mental retardation.

LEWIS: Or mental retardation if someone enters an institution.

HARRISON: Okay. But you want to find that out, do you not, because there's specialized services that have to be provided to those people?

LEWIS: When someone's in an institution.

HARRISON: Right.

LEWIS: Right.

HARRISON: Okay, and that's the purpose of...

LEWIS: The PASRR.

HARRISON: ...the level one is it not, to determine if they have diagnosis to determine whether they need specialized services.

LEWIS: Well, I can't say whether it's the level one or the level two but it would be one of them to determine which one requ—one of them determines whether or not a specialized service package would be appropriate.

HARRISON: Okay. And would you read the second half of this for mental retardation, what specialized services are?

LEWIS: Okay. The second half of this page says for mental retardation, specialized services, excuse me, are the services specified by the State which, combined with services provided the NF or other service providers, results in implementation of an individualized plan of care that—do you want me to keep reading?

HARRISON: Uh-huh.

LEWIS: Number 1, provides specialized and generic training, treatment, health services, and related services that is directed towards; number 2, requiring the behaviors necessary for the client to function with as much self-determination and independence as possible and number 3, preventing or decelerating regression or loss of current optimal functional status.

HARRISON: Okay, do you know if South Carolina has promulgated any regulations to define what specialized services are?

LEWIS: No, I believe I testified earlier that specialized services is not part of my role with the Agency.

HARRISON: Okay, but tell me what your role—and what's your background?

LEWIS: My background here is working as the Administrator for the two waivers I identified.

HARRISON: I'm sorry. What's your educational background?

LEWIS: It's—I have a degree in Health Care, a Bachelor's of Science degree with a major in Health Care (unclear).

HARRISON: And what—did you have medical training?

LEWIS: No.

HARRISON: What med—no medical training, right? Okay. And where did you go to school?

LEWIS: Appalachian State.

HARRISON: And what degrees do you hold?

LEWIS: I just hold…

HARRISON: Just a Bachelor's, there's no graduate work?

LEWIS: No.

HARRISON: Okay, and what—where have you worked prior to coming to HHS?

LEWIS: Here. This is where I started.

HARRISON: And tell me what your title is.

LEWIS: A waiver administrator.

HARRISON: Okay, so you're responsible for the administration of the whole MR/RD Waiver, is that correct?

LEWIS: Right.

HARRISON: Okay. And you were involved in getting that waiver approved and I guess making the changes. Tell me how it came about that that—those amendments were made.

LEWIS: Well, in the first place, it's not an amendment, it's a renewal.

HARRISON: Okay.

LEWIS: And I was responsible in conjunction with many other people. It's not a single effort.

HARRISON: What was the reason for making the changes to the waiver?

LEWIS: It—every five years a waiver has to be renewed.

HARRISON: But what was the reason for reducing the home-based services?

LEWIS: I think as Ms. Priest testified earlier, there were many reasons. There were—there were assessments done by DDSN that they felt like services were not being applied properly to—according to the definitions of the services in place and there were services being over utilized or services being misutilized. There were services that were being underutilized; this is an extremely generous service package for this Waiver as compared to some of the other eight waivers that the State offers and I think that the State and DDSN felt in conjunction that it was just time to re-evaluate it just like we do every five years.

HARRISON: Was that—are you familiar with that notice that went out?

LEWIS: The December 1, 2009, I am?

HARRISON: Right.

LEWIS: I was at the time. I haven't looked at it since.

HARRISON: Okay, how were you involved with that?

LEWIS: I didn't help write it if that's what you're asking.

HARRISON: Okay, but you weren't—as a Waiver…

LEWIS: Administrator.

HARRISON: …Administrator, you approved it?

LEWIS: No, I didn't approve that because it wasn't released by this Agency. I knew about it because we asked them to make sure that families and clients were aware that changes were going on but I didn't write that particular document.

HARRISON: Okay, but you're—HHS is it not, is responsible for assuring CMS that all the Waiver requirements are being complied with, are they not?

LEWIS: You mean the assurances?

HARRISON: Right. Well, no, I'm talking about the, the prohibition about delegating 431.10, the prohibition against delegating administrative discretion or supervision of the plan. Are you familiar with that?

LEWIS: This is not what we considered a plan. The plan of service is an entirely different document.

HARRISON: Okay, no, I'm talking about the State Medicaid Service, the Agency must not delegate other than to its' own officials, this is 431.10 E.

LEWIS: Right.

HARRISON: The Agency must not delegate other than to its' own officials authority to exercise administrative discretion and the administration or supervision of the plan or to issue policies, rules, and regulations on program matters.

LEWIS: Right.

HARRISON: So doesn't the buck stop with HHS on policies and program matters that DDSN does?

LEWIS: We considered that December 1, 2009 a courtesy announcement. Our obligation for public notice had been—we felt like had already been met in other venues.

HARRISON: So this was just a courtesy announcement that those…

LEWIS: …changes were coming about.

HARRISON: …changes were coming?

LEWIS: Uh-huh.

HARRISON: Did—and if we had one for the witness, the notice, do you have yours? Here we go. Do you mind if she looks at it?

HEPFER: No.

HARRISON: Could you, could you looking at that tell me what that paper told families was the reason for the changes?

LEWIS: I don't know that the reason is in here and I believe that both of the witnesses or at least the service coordinator has already testified that she didn't see the reason either.

HARRISON: Do you see the reason for the changes in there?

LEWIS: I see in here that the Centers for Medicare and Medicaid Services had approved it and so the changes would go into effect.

HARRISON: Okay, could you rec—tell me where in that notice it, it has the regulations or the law upon which the, the reductions were being based.

LEWIS: It's not in here.

HARRISON: Okay.

LEWIS: And that's already been stated earlier.

HARRISON: Okay, but you're a different witness. I'd like your opinion. It's important. You do agree with me, do you not, that HHS may not delegate administrative discretion to issue policies, rules or regulations on program matters?

LEWIS: And as that's—I'll state that we don't consider this a policy, rule or a regulation.

HARRISON: Okay, my question was…

LEWIS: And I agree with you and I'm saying we don't consider this a policy, rule or regulation.

HARRISON: Okay.

LEWIS: I said this was a courtesy announcement.

HARRISON: That was a courtesy announcement? Okay, is it HHS's responsibility to assure that notices that meet the regulations go out before service are reduced?

LEWIS: That is the intention. That is our intention that service coordinators do provide, that DDSN makes sure that service coordinators provide those services, yes.

HARRISON: Okay. And what do the notices have to include?

LEWIS: They are supposed to include the effective date, service that is being affected, and the reason.

HARRISON: Okay. Do they also have to include the regulation or the law?

LEWIS: I would agree with you that they probably are supposed to include the law.

HARRISON: Is that a requirement?

LEWIS: I think it probably is.

HARRISON: Now is there someone other than you that's responsible for the administration of the waiver here at this Agency?

LEWIS: Well, there are many waiver administrators here.

HARRISON: Okay, the MR/RD Waiver.

LEWIS: I work in conjunction with several people so different ones of us handle different aspects of the Waiver program. Different things flow through different areas.

HARRISON: But are you the general administrator of the Waiver, the MR/RD Waiver? Okay, and you do agree with me that you may not as the State Medicaid Agency issue polices, rules or regulations on program matters? You may not delegate the—I'm sorry, you may not delegate the authority to another entity to issue policy, rules and regulations on program matters.

LEWIS: It is the Medicaid Agency's authority to handle those matters.

HARRISON: And under—you would agree with me under 431.10 E 1. 2., you may not delegate to anyone else authority to issues policies or regulations. Would you like to look at the regulation?

LEWIS: No, I don't need to look at that. DDSN operates as our Agent for operations. The Medicaid Agency is administratively responsible for the matters that you just stated.

HARRISON: Can they issue policies, rules, or rules on program matters?

LEWIS: They do issue policy and rules but they do so with our input and with our, with our approval.

HARRISON: So do you have to—do you approve every policy and rule on program matters?

LEWIS: We are supposed to work together regarding policies and rules on program matters, yes.

HARRISON: Do they get, CMS, do they get HHS's—do you review every policy and do you agree every rule before they're implemented by DDSN?

LEWIS: No. We only work together on Waiver matters.

HARRISON: Okay. Let's talk about, for example, their policy that says that if you go to an Adult Day Health Program, you can't get nursing services at other hours during the day. Is that your policy?

LEWIS: That was a policy that we worked together on, yes.

HARRISON: And you approved that policy?

LEWIS: Our Agency did approve that policy.

HARRISON: Okay. Do they have policies that you don't approve?

LEWIS: If you're asking...

HARRISON: That have to do with the Waiver?

LEWIS: If you're asking me if they have come to us in the past and asked for things and did we not approve it, the answer would be yes.

HARRISON: Okay, but do you approve every policy?

LEWIS: No.

HARRISON: Okay.

LEWIS: And that's why I said no. We have—there have been things that we have not agreed to.

HARRISON: Have you approved their policy of allowing some people to get more services than the cap under the Waiver and not allowing other people to get those services?

LEWIS: The cap—you mean the cap in the renewal?

HARRISON: Uh-huh.

LEWIS: The service caps. The service caps are the service caps as far as I'm aware the only people who are exceeding the caps are the people who are currently under appeal.

HARRISON: Okay. Are you aware of the decision by the Administrative Law Judge saying that because those caps are a binding norm, they're invalid?

LEWIS: That's not anything I can speak to.

HARRISON: So you're not aware that the Administrative Law Judge has said that because those caps established a binding norm, they're unenforceable?

LEWIS: I really can't speak to that with any authority, no, I'm sorry.

HARRISON: But you're the administrator for this MR/RD Waiver in this Agency?

LEWIS: That's correct.

HARRISON: Okay, are you familiar with the Barbara Hickey decision?

LEWIS: I have been involved in that case to some degree, yes, but I can't—I'm not aware of any decisions, no. I can't speak about any decisions with any authority.

HARRISON: So are you aware that in that case, Hickey vs. HHS...

HEPFER: Madam Hearing Officer, she's asked the same question several times and Ms. Lewis has testified that she wasn't aware of the case and couldn't speak to it.

SCHINDLER: Do you have a question…

HARRISON: But you testi—you participated in that case you said.

LEWIS: I said I was aware of the case and I was aware of certain elements of the case.

HARRISON: But you haven't seen—you don't know about…

LEWIS: I haven't read the decision, no.

HARRISON: Do you know—have you read—do you know the results of the consolidated case?

LEWIS: No.

HARRISON: Are you aware—so you're not aware that the Administrative Law Court has said…

HEPFER: Madam Hearing Officer, she's asking the same question.

HARRISON: I'm talking about—there could be other cases. I don't know about every case. Are you aware of any case where the Administrative Law Court has said that the caps established binding norms and because regulations weren't promulgated they're invalid? Are you aware…

LEWIS: No.

HARRISON: …of any case that said that?

LEWIS: No. What I'm aware of is that CMS has approved this and allows us to do it.

HARRISON: Okay, are you aware of cases in other States for example, the Crabtree versus (Unclear) case where the Federal Courts have said CMS approval is invalid because it violates the Americans with Disabilities Act?

LEWIS: No, I'm not aware of that.

HARRISON: Okay. Are you aware of the Peter B. case in South Carolina…

HEPFER: Madam Hearing Officer, Counsel is testifying about other cases that she knows I believe that Ms. Lewis doesn't have any knowledge of and it

sounds to me like she is trying to get what she thinks of the holding of those cases into the record by asking Ms. Lewis if she knows about them.

HARRISON: Well, it's very important—these—some of these are cases in South Carolina that are—have to do with a policy that was established by DDSN and some by this Agency that the Administrative Law Court have said are invalid and the Peter B. Case, the Federal Court has said that these caps are—well, they haven't issued a final decision but they've established a preliminary injunction saying they violate the ADA.

SCHINDLER: Did you not ask Ms. Lewis if she was aware of any of these decisions and she said she wasn't?

HARRISON: Well, I was getting ready to ask her about the ADA cases. I've asked her about—she does't—apparently the Director of the Program here at this Agency doesn't know that the Administrative Law Court has said that they're ineffective but I was getting ready to ask her about the rulings on the Americans with Disability Act violation and since this Agency is required to comply with the Americans with Disabilities Act…

SCHINDLER: Well, please state your question and allow her to answer it.

HARRISON: Okay.

HEPFER: You know, again, Madam Hearing Officer, the questions are usually (unclear) in the form of Ms. Harrison's view of the holding of the case and asking someone who has already said that she's not aware of the holdings and the law involved but with that objection I guess we can move on.

HARRISON: Did you consider how these changes, whether they would comply with American's with Disabilities Act?

LEWIS: I did not—we did not pull down the language, so to say, if that's what you're asking me, no, I did not compare the text to the changes, if that's what you're asking me.

HARRISON: Are you aware that at least one Federal Court has indicated that it did not comply with the Americans with Disabilities Act and what have ya'll—well, first of all, are you aware of that?

LEWIS: No, but I am aware that CMS approved the Waiver document so I presume that their, their legal team also reviewed our Waiver submission and felt like it was quite sufficient.

HARRISON: Okay. So you didn't look at the Americans with Disabilities Act and consider whether this would violate that act. You just presumed CMS would make sure ya'll complied with that law?

LEWIS: Our obligation is to submit a document that is acceptable to CMS and appears to meet the needs that will serve as many individuals within the MR/RD Waiver as possible in the least restrictive setting as possible and we felt like that the document that we prepared and submitted would do a very good job of that and it was approved with virtually no bullet back so we felt like we did a good job of it.

HARRISON: In the Pecking Order where does the Federal Court—if a Federal Court says you violated the law, is CMS approving it a defense?

HEPFER: Madam Hearing Officer, the Counsel is asking for a legal opinion of a lay person and I object to the form of the question.

HARRISON: Okay. I'll withdraw that. On the specialized services, who at this Agency is responsible for making sure that MR/RD Waiver participants when these reductions force them into institutions…

HEPFER: Object to the form of the question.

HARRISON: If an MR/RD Waiver participant is forced into an institution because of these cuts, who at this Agency is responsible for assuring that the PASRR regulation is complied with?

HEPFER: Just so you understand, Madam Hearing Officer, we disagree that the people were forced into an institution and that's the way the question was asked. That's why I'm objecting to the form of the question. Just so that it's clear. I'm sorry. You can answer.

LEWIS: Well, until it was announced that Mr. Myers had elected to enter a nursing facility I wasn't aware that anyone from MR had entered an institution and of course a nursing home as opposed to an ICFMR so in my history with the MR Waiver, I'm not aware of anybody else going into an institution

either because of these changes or for any other reason, a nursing home but aside from that I can't answer who at this Agency is responsible for dealing with these specialized services, so I'm sorry I don't have the answer to that.

HARRISON: Okay, so if an MR/RD Waiver personnel, every year under—at any time and MR/RD Waiver person has the right to elect whether they're forced into it or because they say hey, I want to live in a nursing home, they have the right to choose…

LEWIS: That's true.

HARRISON: …Home and Community Based Waiver services versus institution, right?

LEWIS: Right, that's the (unclear).

HARRISON: Okay, and when somebody leaves your services, who makes sure at this Agency that their needs for specialized services are met, an MR/RD Waiver participant, who makes sure that their service needs are met once they, once they leave the Waiver?

LEWIS: You mean once they choose to enter a nursing facility or an ICFMR?

HARRISON: Choose to or they're forced, one or the other. Some people I guess like to living in a nursing home. Most people are forced into it. But either way. Who at this Agency is responsible for doing—assuring that DDSN complies with the PASRR requirements?

LEWIS: Well, I believe I testified earlier that PASRR is something that I'm not familiar with and I believe I testified just a minute ago that I don't know who at this Agency does that.

HARRISON: Okay, is it no department that is assigned to do PASRR's?

LEWIS: CLTC nurses do PASRR's in the community and then DDSN has a staff person who also that I'm aware of that also does—has involvement with the PASRR completions as well.

HARRISON: Okay, so when DDSN decides a service is necessary, a specialized service is, what are some of the specialized services?

LEWIS: I don't know.

HARRISON: Are the Waiver services considered specialized services once someone goes into the nursing home?

LEWIS: No.

HARRISON: So PT wouldn't be a specialized service?

LEWIS: Well, PT can be obtained in a nursing home but it's not a...

HARRISON: What about an augmented—augmentative communication device?

LEWIS: I can't answer that. Once someone is in a nursing home that's out of my realm.

HARRISON: So they just fall off the table?

LEWIS: No, I didn't say that.

HARRISON: Okay, so who's responsible at this Agency for—so you don't know who's responsible for assuring compliance, that they get the services that's they're supposed to get.

HEPFER: Which I think she's testified to several times.

HARRISON: Okay. Tell me about the reasonable promptness requirements. What does—isn't that something within your area? You have to provide services with reasonable promptness?

LEWIS: We—that is something that service coordinators strive to work with the providers to ensure that clients receive services in a timely manner, that's correct.

HARRISON: Is that just something nice to do or is that a Federal requirement?

LEWIS: You're right. There is a—and you mean services or you mean—are you taking about specifically enrollment or what exactly—please clarify your question.

HARRISON: I'm talking about providing services with reasonable promptness. Whose—whose obligation is that to assure that services are provided with reasonable promptness?

LEWIS: Well, once someone becomes enrolled in the Waiver, they have to receive a service within 30 days.

HARRISON: Okay, but what do the reasonable promptness requirements say for example once someone is determined to need—I'm trying to think of

		what—psychological services, what does a 1396 A. A. 8., the reasonable promptness requirement require?
LEWIS:		I can't answer that. I don't even know what you're talking about.
HARRISON:		So you're not familiar with the reasonable promptness requirements? What do you think—you're familiar that the regulations and the statute talk about reasonable promptness, aren't you?
LEWIS:		I...
HARRISON:		You've seen that?
LEWIS:		Yes, at some point in my career I have seen that but I didn't see it today.
HARRISON:		So what does it mean?
LEWIS:		It means that clients are entitled to the expectation of receiving services within a reasonable amount of time.
HARRISON:		And what does the Federal regulations, what do they say is a reasonable amount of time?
LEWIS:		It think it's either 45 or 90 days but we require that clients receive services within 30 days of Waiver enrollment.
HARRISON:		From the determination of medical necss—or the request for the services, how many days do they have to provide those services? I'm not talking about eligibility, you're right, 45 or 90 days depending, but actually provide the services, how many days do they have?
LEWIS:		I—can you just ask that one more time?
HARRISON:		Okay.
LEWIS:		You've got me mixed up when you interrupted.
HARRISON:		If a person needs nursing services...
LEWIS:		Right.
HARRISON:		...how many days once they make the request for nursing services does the Agency have to provide them?
LEWIS:		Are you saying do we have a standard that allows the provider to wait before they actually go into the home?
HARRISON:		Okay, if someone's determined to need nursing services, can the local board or DDSN wait six months to provide it?

LEWIS: No, that wouldn't meet what I think anyone considers reasonable. If there is a need that all parties establish and the need is put on the plan after it's been assessed then I don't think six months would be considered reasonable.

HARRISON: Okay, what did the Federal—the Fed's think is reasonable?

LEWIS: Well, I think I just testified that it's 45 or 90 days.

HARRISON: Okay. Tell me about the feasible alternatives provision of the Medicaid Act, the regulations say that once a person is eligible for the waiver, they have to be informed about all feasible alternatives, doesn't it?

LEWIS: It might but I can't speak to it very well right at this moment. If you have something you want me to look at, I'll be glad to look at it.

HARRISON: You're not familiar that it says that services must be provided with reasonable—I mean that feasible alternatives have to be provided to the, to the individual? You're not familiar with the feasible alternatives?

LEWIS: I have probably discussed it with people from time to time but I don't...

HARRISON: What does that mean?

LEWIS: I'm not sure what context you're referring to.

HARRISON: Okay. Do you agree, don't you that once a person's on the waiver they have to be informed of all feasible alternatives under the waiver?

LEWIS: Are you speaking about placements in terms of locus? Are you speaking about providers? Are you speaking about services?

HARRISON: I'm talking about services.

LEWIS: Yeah, well, my understanding and what we have asked DDSN to do is that once they develop the plan with the family and other interested parties, they are supposed to discuss all service—services available that would help meet the identified needs.

HARRISON: So they need to let people know what those services are.

LEWIS: Right. To help meet the identified needs.

HARRISON: Okay. What are your criteria for determining medical necessity?

LEWIS: We—we don't necessarily use medical criteria.

HARRISON: Okay, what's...

LEWIS: This Waiver is not based on medical criteria.

HARRISON: What criteria do you use to determine medical necessity?

LEWIS: This Waiver is not based on medical necessity.

HARRISON: So you're saying—you're saying you don't look at medical criteria?

LEWIS: Not per se'. The different services may find medical information to be very helpful and so for certain services such as nursing or PC II or ADHC, ADHC nursing for example, it may be particularly relevant but for other services it may be less relevant.

HARRISON: What weight has to be given to the opinion of the treating physician?

LEWIS: It's my understanding that service coordinators give equal weight to all of the information that they would gather for whatever service they're gathering information for.

HARRISON: So they'd give equal weight to what—what are the factors that equal weight is given to?

LEWIS: Well, they would speak to the family or other support network within the home, any grandparents that might be providing care, any teachers that might be involved, any work day activity or work program providers that might be involved. They might speak to the physicians or the nurses that are routinely involved in providing medical care, any caregivers that are going in on a routine basis, so it's, it's a combination of record-gathering that they do and they don't necessarily say that one record gets 75 percent or one record gets 10 percent. They try to create this holistic picture is my understanding.

HARRISON: So they'd give equal weight to the opinion of the workshop or the DSN Board versus the family versus the doctor?

LEWIS: It is my impression that they try to attain a more holistic picture so I guess to answer your question, yes.

HARRISON: So are there any regulations about what weight they give to the doctor versus the DSN Board versus the mom or the grand mom?

LEWIS: Regulations, no, not that I'm aware of.

HARRISON: Okay. Are there any regulations on the administration of the Waiver, the MR/RD Waiver?

LEWIS: You mean other than the Federal sites that you were referring to earlier?

HARRISON: Right. Any State regulations.

LEWIS: There, there is the State Code that references DDSN's authority as the State MR/RD responsibility and what that entails for them.

HARRISON: Are there any regulations that determine how, how medical necessity for nursing services is determined or a service like that, any of the Waiver services, are there any regulations about how that's determined?

LEWIS: No, because that would assume that we based this Waiver as a medical model and we don't.

HARRISON: So if a physician determines that a person needs nursing services, that's not given greater deference than the local board or other, other factors?

LEWIS: As a rule, no. As a rule each piece of information at the time is considered together, however, with that said, it's my impression that there may be times when there have been certain changes in circumstances or you know dramatic events in a client's life which might cause one piece of documentation or another to carry more weight.

HARRISON: So the—help me understand how this works. A service coordinator gathers all these pieces, gets information from the mom, gets information from the doctor, gets information from the Board, and puts them all in a basket, then who makes the decision about whether that service is awarded or not, based on all of those factors?

LEWIS: My understanding is the service coordinator analyzes all of the information that's been gathered, the information in the basket so to say, excuse me, and then after having had the conversations with the family and whomever about what services would best meet the needs that have already been assessed would—service coordinator would propose a plan and then meet with his or her supervisor and/or executive director.

HARRISON: Okay, and does that executive director have the authority to override that decision?

LEWIS: Regarding the proposed…

HARRISON: Regarding whether the service—no, regarding whether that service will be provided.

LEWIS: You mean for example if someone proposed that they wanted to offer ADHC, could the executive director say no, I don't think (unclear).

HARRISON: Right.

LEWIS: I suppose they could but I'm—I'm really not privy to what the Board can or can't do. I suppose they could.

HARRISON: Do you—how do they know—how do they know who gets to decide? Are there, are there written criteria—how do they know who gets to decide what?

LEWIS: There is, the MR Policy Manual outlines for the service coordinator the steps that tell them what they do and the preparations of the plan and who they have to work with and who then works with them for the next step of approval and so forth and so on.

HARRISON: And who writes the manual?

LEWIS: The MR service—excuse me, the State Coordinator for the MR Waiver at the State Office at DDSN in conjunction with some other individuals at State Office DDSN.

HARRISON: But who is, who is the person who's responsible for that?

LEWIS: Right now they—that position is vacant at DDSN.

HARRISON: And who's the next person up the chain?

LEWIS: Right now it would be Janet Priest.

HARRISON: Okay. Have ya'll as the administrator, have ya'll given any thought to promulgating regulations?

LEWIS: That's not something that I can address. Perhaps Mr. Hepfer can speak to promulgation a little bit better than I could.

HARRISON: But have to your knowledge, has anyone that works for you or anyone directly above you discussed whether you should promulgate regulations or not?

LEWIS: I believe I just answered that that's not a question that I can answer. That's an issue that our Legal Staff is going to have to address.

HARRISON: My question was have you discussed it with anyone?

LEWIS: I have discussed it with our Legal team.

HARRISON: Have you discussed it with anyone…

LEWIS: And I don't have an answer for you.

HARRISON: Have you discussed it with anyone other than your lawyer?

LEWIS: Uh-uh.

HARRISON: So nobody…

LEWIS: Other than, other than other Waiver staff people in that we've discussed it with our legal team.

HARRISON: Well, not—I don't want to know about what you discussed with your lawyer but the discussions you had outside of your lawyer being there, what did—what ideas were tossed about about whether you should promulgate regulations or not?

LEWIS: We didn't have any ideas. Only that someone keeps bringing this up in appeals.

HARRISON: And who is that?

LEWIS: You.

HARRISON: Okay, so ya'll have talked about the fact that Patricia Harrison keeps asking that you promulgate regulations.

LEWIS: No, not keeps asking but that you have brought it up on occasion.

HARRISON: But you haven't done anything to promulgate regulations?

LEWIS: I have not.

HARRISON: Okay, do you think that's necessary?

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

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

LEWIS: I haven't.

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

LEWIS: I haven't.

HARRISON: Okay. Are you familiar with the lawsuit filed by PMA to ask DDSN to promulgate regulations about the Waiver that would affect the Waiver?

LEWIS: No.

HARRISON: So you're not familiar with that lawsuit?

LEWIS: No.

HARRISON: That's all I have of this witness.

HEPFER: I have no other questions.

SCHINDLER: Thank you, Ms. Lewis. Is that all your witnesses, Mr. Hepfer?

HEPFER: Yes.

SCHINDLER: All right, Ms. Harrison.

HARRISON: Great. I would like to call Sandra Ray, please. Do you want her to move down here or will you be able—well, I guess if Ms. Lewis sat down there she could sit there too.

SCHINDLER: My recorder's pretty sensitive so unless she's a low talker I should be able to hear.

MYERS: Move the cookies down that way.

SCHINDLER: Yeah, please move them away from me.

MYERS: They tempt you. I'm looking at them.

HARRISON: Would ya'll like a cookie? Yes, can you state your name for the record, please?

RAY: I'm Sandra Ray.

HARRISON: Okay. And Ms. Ray, would you tell me what your educational background is?

RAY: I graduated from the University of South Carolina. I got my BS in Psychology and I got my Master's Degree in Speech Pathology. So I'm a Speech Language Pathologist and then I went to Law school and got my law degree there and then I went back into education and I got my

Master's in Educational Leadership and then I'm in the PhD program getting my PhD in Educational Leadership as well. And I have an Educational Specialist degree too. It's pretty much education and speech pathology.

HARRISON: Have you worked through the years with people with disabilities?

RAY: Yes.

HARRISON: How many years have you worked as a professional with people with disabilities?

RAY: Probably, don't ask me that, a long time. I started out doing Speech Pathology and about twenty-five, at least twenty-five years.

HARRISON: So you're pretty familiar with this population?

RAY: Yes.

HARRISON: Okay. Now at one point I believe you were the Risk Manager for a national organization?

RAY: Right, right.

HARRISON: Tell me about that.

RAY: Okay. I worked for Mentor, National Mentor Company and I was their Risk Manager for—they're a company that did—provided services for emotionally disturbed children, developmentally disabled children and adults, brain-injured persons all over the United States. They were in about 35 states at the time and I was their Risk Manager.

HARRISON: Okay. What did you do as the Risk Manager?

RAY: We reviewed every incident in the company.

HARRISON: An incident?

RAY: Any time something went wrong. Any person within the company would have to do an incident report. They would do the incident report. The incident reports would be sent to me. They would be covering things like abuse and neglect. They would covering things such as, you know, if there was a medical need that was not met and there was a consequence, any lawsuits. All the lawsuits were managed through my office. Within my office we did training and we did quality assurance based on the

incident reports that actually were produced in the company. So anything—just about anything that created an issue of care and the—you know, the—a problem that may have occurred in the care of a particular individual. We would look into it and make sure that corrective action was taken.

HARRISON: So you're pretty familiar based on that experience with what happens when you don't provide the care people need.

RAY: Right, because if—when that happened generally there'd be a consequence, either you know, a medical issue that occurred because we didn't, you know that company at the time, a person in that company may have failed to do what was necessary. And then we would basically look at the incident, (unclear) that particular client but then we would look at it as to the whole company and what training needed to be done to make sure that that didn't happen again, what policies needed to be written to make sure that that didn't happen again, what training needed to happen, you know, so that that situation did not happen again. For example, a big issue with children's services is pool drownings so when we had a situation where a child may have drowned we would look totally at that—I would go out to the scene, you know, provide assistance and support at that site. Then I would come back, the staff that I had worked with would then write and do our policies and procedures, what needed to be happening, what factors needed to be considered to make sure that that didn't happen again and then we would go out and initiate training in all of the offices, you know, to make sure that people knew what to do.

HARRISON: Are you pretty familiar through this experience, various experience, with the use of assistive communication devices?

RAY: I'm a—as a Speech Pathologist, I'm aware of the need. I'm not at the point where I have done speech to the degree that I could you know work with a client and then pinpoint what specific device would be appropriate but I certainly have the competence to say that this is a person who

definitely needs an assessment and you know for us to take a look at what, you know, what kind of device could possibly be of benefit to a person.

HARRISON: Does your experience help you to understand the consequences of not having the device?

RAY: Yes.

HARRISON: Okay. Have you—are there health issues or is it just a socialization thing?

RAY: You want me to speak specifically about Al? Maybe that would be better. With Al, Al—he has cerebral palsy and it's very hard for him to get any part of his body to move according to what his mind tells that body to do. You know, he is flailing, he is, you know, he can't control his muscle tone and it's all areas of his body so pretty much the only way to really gauge what he saying is for him to use eye gaze or he can kind of move in one direction or the other but you can tell that he understands what you're saying. So if you ask him a question, and what happened that made this so poignant was we had a situation where I was appointed as Guardian Ad Litem in the Probate matter. Ms. Myers had brought an action to be named as his guardian and you know they appoint a guardian ad litem and during the pendency of that, that's the role that I took and as part of that my job was to interview him and so they had asked me to interview him because of my speech background but during the pendency of that situation we had two incidents at the day provider for Al in which Al had injured his arms or his arms had become injured. And then there was a second situation in which he had come home with fluid all over his body which was basically his nourishment. It had leaked out all over and so…

HARRISON: And now tell me where this happened.

RAY: At the day care provider.

HARRISON: At the Adult Day Health Care or…

RAY: Right.

HARRISON: …the DSN Board? The workshop…

RAY: The workshop.

HARRISON: …or the nursing day health?

RAY: The workshop, the workshop.

HARRISON: Okay.

RAY: And what happened especially with the arms, he had come back with bruises on his arms and so because we just had the—Ms. Myers had just brought her action in Probate Court, the concern was where did that happen? So I went and interviewed Al and I had—before that could happen I had worked with Ms. Myers to make sure that Al—I was introduced to Al and that he knew who I was and that I was a safe person to talk with so Ms. Myers introduced me to him and we had some conversation with Ms. Myers present so he knew I was a safe person to talk to and then at that point in time I started just having my own conversations with him.

HARRISON: Was anybody else there?

RAY: No, no. But the point of it was that this—this young man can talk—he can communicate with you. He just can't get his body to actually talk to you. He can look, he can what Ms. Myers call smile, but he will try to show you with his facial expression that you un—that he, that he is trying to tell you something and so what the communication looks like is you trying to guess what he's going to say and then him either nodding or smiling or moving to the right, to the left, with his arm or looking to the right and the left but you can clearly tell that this—it's kind of like Steve Hawkings, you know who I'm talking about, the astronomer? He can communicate but it's up to you to figure out the question and then he can tell you yes or no. And what happens is because of his medical issues, you know with the cerebral palsy, he still can't control his body, the fine motor coordination and if he gets excited, if he gets excited then he starts to flail so you have to be really patient when you talk with him so when you speak with him, you can ask him a question and he'll either, you know, try to turn to the right or try to turn to the left or look cause you'll say look here for yes, look here for no, so you're kind of watching his eyes but he can pretty much answer any questions and what was important

is when his arms got injured we couldn't figure out where that was happening or what had happened and so it was real important for him to tell us where that was happening so that we could figure out—because it happened on more than one occasion. You know when Al would try—when you push Al through a doorway in his wheelchair his hands would sometimes you know, and if people kept pushing it would hurt him. But the point was he could tell us, you know, he could tell us which arm. Or he could tell me which arm and where it happened but it was pretty much up to me to come up with questions. But what is weary for him is as he gets tired he can only—I mean you can only communicate with him for maybe five or ten minutes before hN kind of gets exhausted because it takes a lot of energy for him to try to get—to look over here or try to look over there and then you have to wait for his body to calm down. So in other words, you'll ask him a question, he'll get the answer and look over here to the right like if the right's yes but then he'll be flailing and then you have to kind of wait for his whole body to sort of calm down and then ask the next question because you're trying to look for which but it's all yes or no. But I think my point is is that he can tell you if he's injured. He can tell you if he's hurt and he can tell you if things are not safe and so my concern when I got involved was that we don't have an assistive technology or an augmented device for him because he certainly could use eye gauge—gaze, you know, to talk with you and he may be able to spell. He's gone through—you know, he's gone through high school and a lot of times when you have children who are so unable to use their body, their minds are very active and they are learning and they may even learn to be—they may even be able to read but you can't tell because they can't tell you that they can and so part of learning to use an augmentative device is figuring out things like can he spell? Because if he can spell then that really opens up you know a whole lot of opportunities for him to be able to communicate. You know, the other thing is is you know what are his needs that he would want to communicate in the course of the day? How,

you know, somebody would need to work with him about how to tell you that he's hurting or has a medical need. So my concern was that he does not have, you know, any device and technology has changed so much. He did have one I think when he was 18 and out of school but it did not work out in the long term when he transitioned to adult services but nobody has really looked at his need since then and he's now in his mid-thirties and technology has changed so much that think about how wonderful it would for him actually to be able to communicate and not have somebody trying to guess what he wants and him saying yes or no. So that's my concern about the speech and I, you know, I feel really passionate that, you know, that he does, that he does—that there's a lot going on in his brain. There's a lot that he can communicate. We're not always as patient as we can be to get the answers to those questions because of his you know his physical needs but I think—you know I think that he can tell you if he's hurt and you know what his medical needs are. He's very fragile medically. You know, he's, he's fed with you know with you know he doesn't eat. You know, the whole issue of his body and just you know him—he's very constricted right now so we can't always anticipate. He needs to tell us when he's injured. So.

HARRISON: From your experience through the years working with people with contractures, how, how, what happens when those people don't get PT anymore?

RAY: Well, they, and I think you've got the physical therapist but they get more and more constricted and it's harder, it's harder for them to move—right now he's moving his body by pointing to the right and pointing to the left, you know, with his hands and his body trying to get over to the side. You know, so, you know he's not going to be able to do those kind of things in terms of communication. And the other thing is he can't move, you know, so, you know, if he's hurting, he can't tell you if he's hurting. If he needs to be moved he can't tell you that he needs to be moved but if he had an augmentative device he may be able to tell you those things.

HARRISON: You've read the PT evaluation.

RAY: Uh-huh.

HARRISON: Based on, I know you're not a physical therapist, but based on your many years of experience working with people with severe CP, do you concur with, with…

RAY: Oh yes, yes. You know, I mean Al can't even tell you he's hungry unless you anticipate to even think to ask him the question.

HARRISON: Are contractures painful?

RAY: Yes.

HARRISON: Are there spasms or…

RAY: Well, he has just a lot of extraneous movement (unclear). His muscles do go into spasms and there's not a lot they he do to stop that.

HARRISON: Is, is it a problem in facilities and in people's homes with gastrointestinal obstructions with people like Al?

MYERS: Infections.

HARRISON: You can't talk. I mean did you have when you were mentor with the risk management, were there issues with people…

RAY: More issues with that I saw in terms of you know aspiration and in terms of you know in terms of ulcers developing from not being moved as frequently as they need to be moved, as opposed to that.

HARRISON: Are these health issues that…

RAY: But you always want—if a person can tell you're they're in pain or if a person can tell you that they're hungry or if a person can tell you that they need something done for them medically, that's, you know, that's so much more appropriate because otherwise somebody's guessing. It's like an infant, I mean you don't know why a child is crying. You have to try to figure it out and if the communication is only as the good as the person making—doing the guesswork unless you get someone the wherewithal to speak for themselves.

HARRISON: Is it something that could avoid hospitalization?

RAY: Yes.

HARRISON: Tell me about that.

RAY: Well, in Al's situation you know in terms of you know—well, let's take for example when the feeding tube came out. The feeding tube came out at the day program and he came home with just liquid all up and down his pants everywhere. He could have shared that with us. Now if he's going to be sitting in liquid for a long period time, that's going to break down his skin. You know, obviously if it breaks down his skin, he's more likely to have ulcers. Ulcers are very—and I can't speak medically other than to say it's a real big risk issue for people who are not able to move on their own. So that would be a real—something that's very likely to happen to this young man is…

HARRISON: So if he's able to communicate these needs he's less likely to go to the hospital?

RAY: Right, well he would be able to say you know there's liquid all over my—all over my pants and all over my underwear plus he didn't eat because all that fluid went—didn't go into his stomach. It went you know everywhere else. But it's just those kind of things that you and I would think to go to the doctor for or tell someone that we need to go to the doctor. If you had an earache, I mean just any—I mean anything can move into infection but he needs to be able—if he can tell us we need to help him to tell us.

HARRISON: Now you were involved, were you not—didn't you get appointed right after the injury to his arm?

RAY: Yes.

HARRISON: And was he injured at that workshop more than once?

RAY: Yes.

HARRISON: Based on your history of risk management and you know, we've heard that there's an array of services that he could choose from. Is that a safe service for Al?

RAY: I think the problem came because it was really hard for us to pinpoint where the injuries occurred, were they intentional or not, what happened,

you know, that this injury, these injuries to his arm kept occurring and it was very—oh, I'm sorry, ask me the question again.

HARRISON: Well, my question is and let's say if it was your child, would you feel safe sending him back to that?

RAY: No, no, no, because we weren't able to pinpoint it. You know...

HARRISON: Do you know it happened there?

RAY: Yes. Well, I knew it happened there because I interviewed him and he was able to tell me so but I mean it took us a good, a good 45 minutes to....

HARRISON: Okay, when something like that happens, now did it require hospital treatment?

RAY: Not this, no, not at this point but it did require hosp—it did require us taking him to a physician.

HARRISON: Okay. When something like that happens from your experience with the risk management mentor, is there a requirement that that be reported?

RAY: Yes, if that particular company that was a provider company, an incident report would have been generated for that.

HARRISON: And is that State laws?

RAY: The reporting of abuse would be or neglect would be. Just the fact that it had—there's a suspicion of neglect, it doesn't mean that there necessarily was neglect or that it was done on purpose. It just means that it should be looked into and it should be analyzed.

HARRISON: So did you—did—was—when you became appointed as GAL, was—were you—was there any indication it was reported?

RAY: No. What had happened is that the local board had told Ms. Myers that they were going to report it. I called to verify that it had been reported. It had not so then I made the report because it hadn't been reported.

HARRISON: And then it happened again, is that correct?

RAY: Uh-huh.

HARRISON: Let's talk a little bit about the Adult Day Health nursing. If a person is going to that program, does that negate that person's need for nursing during other hours of the day?

RAY: I think if you need nursing services you need it when the service is needed. You know, you can't pinpoint necessarily, you know, that you can only, you know, four hours a day, you can't pinpoint when they're going to necessarily need all four hours. Things come up during the day with a medically involved person that may require some flexibility in when those times, you know, when nursing services are actually needed.

HARRISON: If a person like Al had four hours a day of personal care services, what's the problem with limiting it to those hours because the actual event of changing the diaper only takes 15—well, however long it takes, 45 minutes, 15 minutes, whatever it is, what's the problem with just limiting it to that number of hours?

RAY: Well, the problem with people that can't move is the issue of skin deterioration and so say for example when the fluid, you know, his liquid nutrients were all over him, you know, that was a major production for a person you know as medically fragile as him because he had to be lifted, everything, you know, he had to be cleaned up, you know, every—you had to figure out how much nutrients he had and that had to be redone again. He was sitting in it so his skin needed to be assessed just to look to see you know if it had caused some more—some deterioration. I mean it's just—everything is—for a person that's medically fragile, everything is significant.

HARRISON: Based on your…

RAY: Especially skin stuff.

HARRISON: Based on your experience with people who have disabilities like Al, why are psychological services important?

RAY: Psychological services? Because if you have an emotional difficulty and then you can't speak about it, you can't solve—it's hard to solve problems or to get the support for somebody from somebody else to even help you

to solve a problem. I mean think of all the ways that we all use communication to make our way in the world. He has no way of making his way in the world so communication is a major, you know, a major issue in resolving grief. You know, resolving grief requires a lot of, you know, a lot of communication of talking about the person who has passed away, about you know, reconstituting your life now that that person is gone. And in his situation, he lost a caregiver who had been with him for years and years and years. It wasn't—it was like a family member. So, you know, for somebody who can't communicate they also are frightened about how life is going to change for them. You know, who's going to be providing the same services that person had provided? You know, who's going to you know who's going to fill that void of companionship? Are—you know, but the whole—and just coming up with—you know, we talk to get—to have people help us solve problems and help us come up with alternative ways of dealing with things. He doesn't have that. So in terms of giving him a counselor that is patient that realizes it's going to take him five minutes maybe to say or three minutes to say yes or no to your question is important. You know so you know I just—you know when you can't communicate it's just such a, you know, it's such a disability you know in terms of making your way in the world and resolving emotional difficulties you might have.

HARRISON: Is there any—the fact that he's going through this transition, does that increase or decrease his need for the psychological services?

RAY: I think right now it would increase because right now he's just lost his mom in terms of her providing daily care. He's now moved into a nursing home so the question is now he's totally dependent on all kinds of people who are strangers to him and you know he's always felt a sense of safety at least knowing that his mother would be looking behind and making sure everything was fine so to me that would be a major life change.

HARRISON: Now have you read the affidavit of the treating physician and the June, I think it's 24th, letter about, about the services? It's this letter, do you have it?

RAY: Uh-huh.

HARRISON: If those services had been provided based on what you know about Al's situation, would he have been able to remain in the community? If they had been provided at that time.

RAY: The thing that's important about remaining in the community is that the caregiver is so attune to the needs, the physical and emotional needs of the person, that they can anticipate the needs especially when you have a person who can't speak for themselves so I think that's the thing that is so important is keeping him in a situation where somebody is in essence the expert for him and about him. And at this point I think what happened is that Ms. Myers, you know, she's getting older, she's having her own medical needs at this point in time. She's isn't able or she isn't able to do everything for him and with the cuts, you know, in terms of having people to help her, she, you know, she wasn't able to absorb the additional responsibilities that came with that. But the best place for him would be at home because she knows him and she can predict for him and she has, you know, she knows the nuances of his behavior. She knows the nuances of how he might—how he responds when he is injured or he is sick or some medical need is occurring. So, you know, that's why the—that's why serving somebody in the community or with a family is so much better because they can prevent those kind of things. But they can only do so much. And I think that would be, would be my impression as to, as to what's happening.

HARRISON: Is depression an issue, a concern once he—now that the reality is that based on the breakdown he's, he's in a facility now? If—what are the risks, (unclear) risk management, what are the risks if these specialized services required under PASRR are not provided?

RAY: I think you just need to look again at his medical needs. He's medically fragile. You know, you have the very special need of making sure that he's moved from time to time because of the skin deterioration. You have a major issue with respect to you know keeping him as flexible as he can be with his extremities because as he slowly closes up you know he's not going to be able to sit. You know being able to sit is a major—it's a major, I mean to us, we're all sitting around here and it's no big deal but for somebody, if you lost that ability then you're in a bed.

HARRISON: Now does he have a molded device?

RAY: No, I don't believe he does.

HARRISON: On his wheelchair?

RAY: He does—I'm sorry.

HARRISON: Okay, so you're not familiar with the device?

RAY: No.

HARRISON: Okay.

RAY: You just need to be very careful about you know trying to keep him as flexible as you can and not let him—just like if you didn't use your arm, I mean eventually it kind of will close up and so he can't—he can't exercise himself, you know, to keep, you know, to keep his body flexible and you want that because that's how you can move him easily. As he curls up it's harder to move him as you know a person from the outside. You know, like if I tried to take your arm, it's easy for me to move it but if you started to constrict up, I'm not going to be able to move you. You're stiff.

HARRISON: What about infections, is that affected by the PT and I mean would that…

RAY: I think anytime he can't move on his own then he's going to end up with just the pressure sores.

HARRISON: And would that lead to hospitalization?

RAY: If they're not cared for, yes.

HARRISON: Okay. Is there anything else you'd like to share that you think would help the Hearing Officer to understand the need for these services regardless of where he is or…

RAY: I just think the complexity of everything when you add it together and if you drop the ball on any one thing, it can create a, you know, it's all—I mean it starts a pathway of other things occurring. And just, you know, he is so medically fragile but I think the most important thing is that he does have a mind that works. He is thinking. He's engaged with you the entire time that you're in the room. And you know, what—you know whatever we can do, you know, to make sure that he gets what he needs, I would just advocate for that.

HARRISON: Thank you.

HEPFER: Okay, so I understand your testimony is that he needs a speech generating device?

RAY: Yes sir.

HEPFER: You would advocate that.

RAY: Yes sir.

HEPFER: And do you know whether those are available under the Waiver?

RAY: My understanding is that they are.

HEPFER: Okay. He needs physical therapy…

RAY: Yes.

HEPFER: …to avoid hospitalization.

RAY: Yes.

HEPFER: You'd be an advocate of providing him…

RAY: Yes sir.

HEPFER: …being provided physical therapy. Do you know whether that is available under the Waiver?

RAY: I believe, I believe she testified that it was.

HEPFER: Right. Yeah, I mean she testified it was under the State Plan.

RAY: Okay.

HEPFER: But at least it's available to avoid hospitalization.

RAY: Right.

HEPFER: Right. And he needs grief counseling.

RAY: Uh-huh.

HEPFER: Would you be in favor of him getting that? Do you know if that's available under the waiver?

RAY: I don't know if it's under the State Plan or the Medicaid plan.

HEPFER: Available somehow.

RAY: But if it's available then that's a need for him.

HEPFER: Okay. Nursing services, he needs nursing services in addition to the nursing services that are provided…

RAY: I think what you—I think what you'd have to do is look at…

HEPFER: Let me finish the question.

RAY: Oh.

HEPFER: Sorry. Nursing services in addition to that which is available at the ADHC?

RAY: Yes, but let me clarify.

HEPFER: Sure.

RAY: What you have to do is to look at when certain services are needed during the course of the day.

HEPFER: Oh yeah. Absolutely.

RAY: And then, you know, pinpoint when that could be done and to make sure that…

HEPFER: Sure.

RAY: …it matches what his needs are and not based on the convenience factor of a person who can come in, you know, because it's going to be for short periods of time at various points throughout the day.

HEPFER: And what would that be for, the nursing services?

RAY: The nursing services would need to be done, you know, to deal with you know the issues of…

HEPFER: Tube feeding?

RAY: Yeah, the tube feeding and just checking him for you know, just to make sure that his skin is not deteriorating. I think that would be a very big, big important thing to happen probably daily.

HEPFER: How many times a day would you think…

RAY: I wouldn't be able to testify to that. Just that a nurse would have to determine a plan of care and you know be checking him for those kinds of things on a regular basis.

HEPFER: For some—on a regular basis.

RAY: Yeah, I think you need to look to the physician for that.

HEPFER: Yeah. Okay. Could you assume it would be done at least once at the ADHC?

RAY: I think you'd have to look to the nurse and the physician for that kind of recommendation. I'm just—I'm only qualified to say that there's a risk there.

HEPFER: Perfectly understand. Okay. And how are you becoming involved in this case?

RAY: I became involved in this case because I had agreed to serve as his Guardian Ad Litem in a Probate matter.

HEPFER: And what was the Probate matter?

RAY: Ms. Myers wanted to be named as his, his legal guardian and during the pendency of that action, they appointed a guardian ad litem.

HEPFER: Sure, got it. To protect his (unclear), his guardian ad litem?

RAY: I was his guardian ad litem.

HEPFER: Okay. Thank you. That's all I have. Thank you very much.

SCHINDLER: All right, Ms. Harrison?

HARRISON: I'd like to call Lennie Mullis. Ms. Mullis, we're going to have to swear you in so please repeat after me or actually you can just affirm the oath and then state your name. Do you promise to tell the truth in this hearing?

MULLIS: I do.

SCHINDLER: And please state your name.

MULLIS: Lennis S. Mullis.

SCHINDLER: Thank you.

HARRISON: Ms. Mullis, how, how did—tell me about your background first.

MULLIS: I have spent the last 30 years working with the intellectually disabled, head and spinal cord, autistic population in a variety of settings. I have

taught for the last 17 years. I have been providing psychological services and behavior support services. I was an administrator, the Executive Director of Lancaster County Disabilities Board. For 7 ½ years I taught on various things within the field.

HARRISON: Okay. And now what are you doing with this population?

MULLIS: Right now I provide counseling services and/or behavior support services. Counseling services being—it was redefined in November of 2010 that we are able to provide grief counseling, consultation for sexual assaults, consultation for sexual predators, and I'm so sorry I can't remember the other one, and behavior supports for inappropriate behaviors that interfere with a person's quality of life and (unclear).

HARRISON: Now have you provided psychological services to Al Myers?

MULLIS: I have, yes.

HARRISON: Okay, and are you—are you—has the description of his physical condition been pretty accurate today?

MULLIS: Yes.

HARRISON: Is there anything else you'd like to add to that?

MULLIS: Also, yes I would. Al has scoliosis and it has rapidly increased and I can't be exact, in the last few years it has accelerated which for lack of therapy I think that's one contributing factor. I'm not a physical therapist but I do know in talking with Ms. Myers and Al that that has been noted in the medical records that there has been an increase in his scoliosis enough to warrant another type of wheelchair. I mean that it is his mobility is his wheelchair and he is because of the scoliosis, he is coming out of his chair and if he can't be in a chair, then the only option that is available for him is a bed. So there has been an increase in his scoliosis. The other thing is anyone who is that medically fragile is always at risk for respiratory infections. Mostly pneumonia, bronchitis because if they don't move, the fluids sit and that is a major health concern particularly this time of year and going in and out of facilities and so forth. So you know I just wanted to add that.

HARRISON: What about gastrointestinal, if, if he doesn't have the PD to keep him loose, does that affect…

MULLIS: Persons, with my experience, has been persons with CP have gastro problems to begin with. Their whole system is slower than the person who is mobile and moves and drinks water and coffee and so forth and so on. Their system goes at a slower rate and constipation is always an issue with someone medically fragile and if you're not moving and you already—they always have assistance with different medications such as Miralax and so forth but if you don't move the system clogs worse.

HARRISON: What kind of health—could this lead to any health risks that would cause his hospitalization?

MULLIS: Oh yes, absolutely.

HARRISON: Tell us about that.

MULLIS: You could have a blockage because your system is not what goes in comes out, it's not cleaning out. You can have pneumonia from fluid build and this population like I said is high risk for pneumonia. He had the skin breakdown which if your skin breaks down you're open to MRSA and staph so you have several different avenues that have to be constantly monitored and again, because Al cannot tell you something's bothering him, he had—when I—upon one of my visits, he had a little sore on his foot. The sore got bigger because he can't move and the feet—because the contractures rub so the little sore becomes a big sore and then it has to be monitored and very easily he's open to any type of infection and that would lead to hospitalization.

HARRISON: Would his having an assisted device, would it lessen the risk of his going to the hospital?

MULLIS: Absolutely, he could tell you. If something hurts he can tell you. Right now as Ms. Ray mentioned you have to read his body language and that's something that doesn't take—I started with that in August and for the first two and a half months I watched Al. That's all I did. I watched Al interact with his mother and his caregivers to see how he responded and of course

		mom is a great big smile and he has wonderful eye contact and you have to watch to get a rhythm of what he does and how he responds to something he likes or he doesn't like. But you can also read his body language if something—and you can only ask him if something is uncomfortable, you know, the sore on his foot or the injury on his arm or the uncomfortability of being in wet clothing because of fluid leaking out. So if he had some type of communication device, yes, he could indicate something hurts, something hurts him. For him to say that is an indicator versus you know going through the whole body every time and asking yes or no and it's a very tedious process.
HARRISON:		Will the staff at the nursing home be able to read his needs the way mom did?
MULLIS:		They will—staff will eventually learn Al but nobody knows Al better than his mom. I mean there's—the staff will learn to interpret basic functions of Al and likes and dislikes but there's nobody like his mom.
HARRISON:		Is there a risk in an institution if you're not—if you don't have the device, with substitute staff, even if the staff get to know him well? Have you seen that to be a problem with his population?
MULLIS:		Because of economics and because of work attitudes, you see a lot of turnover in nursing home staff and institutional staff and consistency is always the best policy with this population. Having a consistent staff because it is a staff that has to work several people that work with (unclear).
HEPFER:		Excuse me, Madam Hearing Officer, Ms. (Unclear), you need to check your…
VOICE:		Yeah, go put some money in the meter?
HEPFER:		Yeah. I think they were trying to…
VOICE:		She was trying to tell me and I was giving her one more quarter.
SCHINDLER:		I'm sorry, you should have waved to me.
VOICE:		Wait a minute, I've got another quarter. You got enough?
HEPFER:		I'm sorry to interrupt you.

VOICE: Thank you, Mr. Hepfer. I appreciate that.

SCHINDLER: (Unclear) would you mind (unclear), Mr. French. I'm sorry. You need to wave works so I can see. Thank you, Mr. Hepfer.

HEPFER: Sure.

HARRISON: I lost my train of thought.

SCHINDLER: Okay, Dr. Mullis, go ahead.

HARRISON: What was I saying? I think we were talking about the staff…

MULLIS: Oh, staff changeover.

HARRISON: …changing.

MULLIS: And you, you lose something with inconsistency. You lose that carry over from one shift to another or if the person who's normally on second shift. There's just something that, that, that gets lost in the process of too many changes.

HARRISON: What about the—could you address the PT issues? Have you had a chance to review the PT?

MULLIS: I have and, and, and no doubt someone with that much spasticity and rigidity has to have PT. It's like brushing your teeth every day. If you, if you don't have the stretching and the exercises for the Physical Therapy then he becomes rigid and that leads to again it's out of my expertise to explain how the scoliosis (unclear) but all of that, his body movements and the physical therapy is most important and also the way he processes food, his whole digestive system, his whole well being. If he hurts, he's not going to want to participate in—or not be happy with participating in many things so yes, physical therapy is must.

HARRISON: What about dental services for someone who doesn't have speech? Why is that important?

MULLIS: Your mouth is most important. Even years ago dental was not seen as an important issue but…

HARRISON: …and that was when you were working with this population?

MULLIS: In the beginning when I started working with the population thirty years ago, dental carries—dental caries were not seen as a big issue but as time

has gone on your mouth a very important place. It's a source of a lot of infection. It harbors a lot of infections. You have saliva, you have dental caries. In Al's situation he has a bite that he can bite his lower lip. He has to have a special device because lot's of germs, I mean you can get sepsis in your mouth and it will go all through your body so a clean, hygienic mouth is very important.

HARRISON: So if he doesn't have dental services, now dental services were included under the Waiver, right?

MULLIS: They were. I don't know if they were under the State Plan or not, I'm not sure but he does need and I believe if memory serves me correct, he has to be put to sleep in order to clean his teeth because it's—with someone who contracts like that, you'd have to sedate him in order to give the teeth a thorough cleaning.

HARRISON: Based on your experience working with these folks when you were director, and you work in the community now with people who have these issues?

MULLIS: I do. I work, I'm statewide.

HARRISON: How frequently does that have to happen?

MULLIS: The dental?

HARRISON: Right.

MULLIS: Dental a minimum of twice a year. You know, the same thing that we have with the plaque and the tartar happens to everyone's teeth and it's—the American Dental Association recommends a minimum of twice a year.

HARRISON: Is that something that can lead to hospitalization?

MULLIS: Absolutely, absolutely. If you have a abscess or you have strep or if just have diseased gums, a gum disease, your whole body suffers from that, yes. And it if it's not watched, gingivitis, you can—it will cause the rest of your body to be sick.

HARRISON: Now I believe that you provide services to two of the other three individuals in this consolidated case.

MULLIS: Yes.

HARRISON: M. M. and C. D.

MULLIS: Yes.

HARRISON: Compare Al's needs to their needs.

MULLIS: Each of the individuals in the cases have specialized needs. Some are more medical and some are more—medical needs, we have one of the individuals is tube fed and…

HARRISON: Like Al.

MULLIS: Like Al, and they have someone coming—nursing coming in to assist with the tube feeding three times a day, three or four times a day. And the other gentleman is physically disabled and he is in a wheelchair and he depends on PCA, respite to come in. He cannot move without someone helping him and he did not (unclear) the (unclear) without someone helping him so his, his total well-being is depending on someone else. He has PCA and full respite services all but seven hours of every day and that's mainly when they put him down at night until first thing in the morning, six or seven in the morning but he cannot, he, he does not utilize diapers. He does use the bathroom and he has a Hoyer lift. He has an elder parent living with him and his life revolves around the people that provide PCA and respite services.

HARRISON: When you look at these individuals, are Al's needs any less?

MULLIS: Oh no. Al has and in some respects, his—Al's medical needs are greater than either one of those but they're each individual. They each need—they require twenty something hours a day of care but they have different areas of—one of the gentlemen speaks. The other lady that is tube fed does not. You know, it's—their environment is very different so but they each need medical care and nursing care and PCA care and speech and physical therapy so they still need the services but in different—in different ways.

HARRISON: Can you tell me about—from a—you've worked with the Waiver I guess since it started.

MULLIS: I do, I have.

HARRISON: Okay, and you've dealt with seeing who gets services and who doesn't. Is there any rhyme or reason for denying Al's receiving services over the Waiver compared to other people who it's been provided for? I mean does it seem arbitrary?

MULLIS: You can say it may be where the person lives as to where they access their services from. There is—it does appear to me as arbitrary and capricious how people get services whether it's—they get more or they get less, they live in Camden, they live in Charleston, they live in Columbia. There does not appear to be any set rule. I, you know, I've seen people have lots of services and then I've seen people been—who have been denied services. Many of the people who have been receiving services have been on the Waiver for a long time. You know, it appears to be arbitrary and capricious.

HARRISON: Tell me about the psychological services. Why are those important?

MULLIS: Psychological services. Al is 34 as of December and he in the last five year has had major changes in his life. His father has passed away and you know having lost a parent myself, that's a—that is a significant issue. Grandmother has passed away. Caregiver for numerous years is all of a sudden not there anymore and there's a host of people coming in and out of his house. And most recently Al lived—has lived with his mother for 34 years and all of a sudden he's now in a different place. He goes to sleep at night at a different place. There is some—those are major life transitions and because Al doesn't verbally communicate it takes its' toll. You know change is difficult with people, any person. So you watch very closely to see how someone adjusts, to see how they relate to people. It's a hard transition, you know, and this is his—I mean this is the first time he has left home for a period of time. So yes, you have grief obviously from the people who have passed on from a caregiver who was a family member not being there and now you have a change in where you live. And I'm sure Al understands enough to know well, if I'm here, what's

going on with mom. And I think you know Al is crazy about his mother. He loves his mother. The first thing that I noticed, Ms. Myers cracked a joke about something about gaining weight in the middle and that her son is gaining weight just like his mother and he just broke out into a ha, ha, ha, you know a big laugh, he got it. And you know I mean it was just—Carolyn was just having a random conversation and that's when I knew you know that they're two different people but they're like one person, they're so close. She knows everything about him and he knows everything about her but unable to verbalize it. So.

HARRISON: What—is depression a significant issue in nursing homes?

MULLIS: Yes.

HARRISON: And what can that lead to in terms of mental—I mean in terms of your physical health, how are they connected?

MULLIS: If you don't—if you are suffering from depression, you may not—although he is tube fed, people sometimes do not want to eat, people want to sleep all their time—all the time, their will to survive diminishes. You see lots of situations that are in nursing homes where you know people are suicidal. They just—they bottom out. Also, you know, it's right after the holidays and you know January is typically a winter month and it's cold and people don't get out as much and there's not as much light and there's lots of theories that depression is the strongest in the winter months. So you have someone who has, you know, perhaps, they have physical issues going into a nursing home. They're transitioning after a holiday. They miss their family. You know, in centers there is a higher rate of depression in the first year living there.

HARRISON: Are you familiar with the service of respite?

MULLIS: Yes.

HARRISON: And can you tell me—can you tell me why it's not an acceptable substitute for PCA services?

MULLIS: Respite care is just a—it is a supervision. It has an accountability but it does not provide the same type of services as a PCA. It is not—PCA is a

hands-on service. It does bathing, it does light housekeeping. It does feeding, bathing, dressing. Respite does not do that. Respite just watches a consumer for what they're doing and just checks on them for accountability reasons but does not provide hands-on service so it would be someone who is able to supervise, for example Al, but if you needed changing they're not going to do that. If he needed something to eat, they're not going to do that and you know if he became dirty or he needed a bath, they wouldn't do that either.

HARRISON: Are you finding—you work with people across the State.

MULLIS: I do.

HARRISON: And you work with people who live at home?

MULLIS: I do, yes.

HARRISON: Okay. Do you have people that are allocated respite hours that can't find anybody to work them?

MULLIS: Yes, there is a horrific shortage of respite providers. There has since the Waiver's implementation, the different boards have taken different approaches. Some boards had a designated staff person to recruit and hire respite workers and PCA workers. Some boards had agencies like Nightingale that they just recommended to people or they have a list of recommended providers. There is not an accurate or easy way to recruit people for respite services. Also, the training is a barrier because if someone is working another job they have to take off to get five days of training during the day and they have to take off their other job and the problem is if they were interested in working a second job, they would be you know staying (unclear).

HARRISON: So they're out of the market, they're out of the pool?

MULLIS: Right.

HARRISON: What about the rate of pay?

MULLIS: The rate of pay, I don't know exactly but it varies in the State probably anywhere from 50 cents to a dollar, depending on where you are. I, I, I know that the rate is different. Also, the fact if a board has a—and there's

an agency that provides the respite but they're titrating that down because the little amount they pay people they're finding that they can't get people to work.

HARRISON: And so the boards are having trouble getting respite people?

MULLIS: Yes. Absolutely.

HARRISON: And families—are they able to…

MULLIS: And then recently many of the families were told that they were going to have to take on being the employer of respite workers and family members did not want to have that liability. You know they're barely making ends meet and then you say this person has to be your employee and they don't want to do that. I mean that puts them even at a greater risk than they already are with not having enough help as it is and then someone come into their house and hurt their back and where are we?

HARRISON: So have you seen families that because the parent couldn't afford to provide that liability coverage or worker's comp or whatever do without respite?

MULLIS: Absolutely. They have been doing without—respite is phasing out rapidly and so what's left instead of families having the PCA hours adjusted back up to compensate for the respite hours not being used, they just lose the respite hours and there's no adjustment to the PCA hours.

HARRISON: I believe you have one client that's zero respite because wasn't she told that she had to become the employer?

MULLIS: She did indeed and she receives no respite and she receives no companion services, same deal with is also a service under the Waiver.

HARRISON: Have there—have there, is that fear that parents have of liability if they're forced to be the respite employer, is that a real fear. I mean do you know anybody that, that has suffered consequences because the respite provider, the boards deny liability for what they do?

MULLIS: There is one case where the respite worker and the consumer were in an accident and the agency did not take responsibility for the respite worker

and the consumer was hurt and what ended up happening was the car, the insurances for the car ended up settling some of the medical claims but they, you know, that was a horrific situation and that led into all—other sorts of problems resulted from that. But families who have had a disabled child or a mentally challenged child or physically disabled or an autistic child, already know when they go into Wal-Mart, their liability walking into a store with a child with a disability and so to say okay, now you're going to assume the liability of someone coming into your house, uh-uh, that's not going to happen.

HARRISON: Now do they assume that same lia—are they forced to assume that same liability if it's a PCA provider or is it just for respite?

MULLIS: It's for respite and companion. PCA, it depends where you are. There are still a few PCA's that are employed by boards, not many, but there are a few but most of them now are through the agencies.

HARRISON: We heard testimony earlier, I don't know if you were here, that, that you can get respite through providers across the State. Is that your experience?

MULLIS: Not at all. I, I, there are very few respite providers because the reimbursement rate is so low that agencies, provider agencies do not want to take that on. They can't make ends meet. Whatever their rate is they have to give minimum wage at least to respite workers and then whatever mileage or whatever they have to pay on top, they're not—they're not making any money with respite services.

HARRISON: Is there anything else that you think that would be helpful for the, for the—let me, let me, you've got the fear of the—you've got the fear of the liability if you, if you are the employer for the respite workers. Are there—are you seeing other fears in the community of families?

MULLIS: Families in working in the community what I have seen since the beginning of the cuts and the, the turn of the economy, you have a family unit that's usually one parent with a disabled child, brother, sister, whatever it is and other family members living in a house, may or may not

be employed, have chosen to keep their loved one at home, and all of a sudden services are being cut. The services that they relied on to manage the other family members or so they could work are suddenly not there, you know, under the pretense of we have a bad economy, we're doing cuts and so forth and they become immobilized. They become overwhelmed. They become not very functional, you know, because they're making decisions you know well we need gas, we need diapers, because those services have been cut. I don't have anybody to stay here. I can't work, you know, this shift. I know several families where they have had to stop work because there was no one to pick up the child after school until they got home and so you, you, you know it—people when they're hit with too many things emotionally they just begin to shut down and then they become dysfunctional and many of the emergency cases that I've had over the last six months have been the family member has—the primary caregiver cannot function anymore. They cannot function. It's too—there are too many things on the plate and they just do not have the supports that are needed to maintain the person in the community.

HARRISON: Based on what you know about Al Myers and his family situation, have you seen the letter of the doctor, the June letter of the doctor? Do you mind if I show that to her? I can't find mine. It's here somewhere. Do you have it—here, we have it right here. If you'd look at that. Based on what you know, if those services had been provided, do you think it would have broken down to the point that Al was in a nursing home now?

MULLIS: I think that if Al could have had the services, the recommended services…

HARRISON: And recommended by?

MULLIS: Dr. Munn. And, and I think that he would have been able to be in his home but I think that the situation was there was no consistency. The staffing situation was very sketchy. The staffing PCA services that she had were grossly inadequate. She needed nursing services also. The adaptive equipment that the service coordinator talked about, the, the thing for the tub, the Hoyer lift, doesn't place him in the tub like you know we

go and sit in the tub. You have to position it. It's kind of out of kilter. The lifting and she cannot do anymore, Ms. Myers, and that's a big issue. Also, because the time of—the limited time of PCA services that was offered, she would often have to rely on older family members to come and take him off the van like her 90 year old mother-in-law when she had an appointment that day so it wasn't always those four hours, there wasn't any flexibility and she, she needed many more hours than that.

HARRISON: And did the change, the respite providers, is that part of that problem with consistency?

MULLIS: Absolutely. You know, again, and mostly families in the community know, they call it the riggamarole. They start off with a PCA. They last maybe three or four months because of the low wages and then you have—then you start all over again and then you have to retrain all over again. You know, whereas if they were just paid more to begin with, you would have more consistency.

HARRISON: Are you talking about PCA or respite?

MULLIS: PCA, PCA too, and respite is virtually impossible.

HARRISON: So it's worse in the respite?

MULLIS: Right.

HARRISON: Is there any concern—you work with people around the State.

MULLIS: I do.

HARRISON: Is there any concern about reprisals if people complain?

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

HARRISON: Have—is there any legitimacy to that?

MULLIS: Well, I, I feel that in, in, in several instances a family, for example a family in another part of the State had a respite sitter, they moved and they had a respite sitter from where they were previously and the new board would not let them use their respite sitter and from the other area unless they were an employee of the new board. Anyhow, they ended up losing

some of their respite hours and they felt that that, whether it was or wasn't, the retaliation was their respite hours got decreased. Where when they lived in another part of the State they had respite hours so you know, you find things like that. Again, very arbitrary and capricious, no rhyme or reason how things are done.

HARRISON: Okay. Is there anything else you'd like to share that would help this Hearing Officer understand Al's situation?

MULLIS: I do have one thing. On the service list that they talked about, I would think also with specialized services for Al, he would benefit from a companion service. We're not talking 40 hours a week. We're talking about Al loves for people to read to him and he does enjoy Clemson football so you know that kind of specialized…

MYERS: Not lately.

(Laughter)

MULLIS: But I, you know, that, that, that service is available and that's, that's not a lot. I will tell you that I had a young woman in another county that was in a nursing home and they indeed provide, the Disabilities Board paid for my services to go in to for psychological services. There were some issues with her there.

HARRISON: So there is a history of DDSN or HHS paying for psychological services once someone's off the Waiver when they're in an institution. Could you take a look at the affidavit of the physician? I've provided that, haven't I?

HEPFER: Yes.

HARRISON: Okay. And tell me if you concur with the physician's assessment of what specialized services are needed.

MULLIS: I do agree with his recommendation and his assessments. One other thing I'd like to mention in, again with some information that was distributed to the nursing (unclear) Ms. Myers was talking about. When Al goes to sleep at night put the blanket under his arms because if it's over his arms when he flails it could go over his face and that is ever so little of a thing but so significant. There was an incident, a DDSN situation where there

was a lady very much like Al and she—they had a geri cap on her. They were doing her hair and they put the little cap on and it slid and she had no way to communicate. I mean those little things if they're—you know with the checking of someone and the care because of the fragility of Al, those little things are so important. There was another thing about, you know, the toenails and the fingernails and the scratching and he's not able to tell you oh my, I've scratched myself, you know, over here on this hand. You have to do a full body scan at all times to make sure that everything's just so but those little things, you know, a mother would know. But I think that that's very important and it also gives you an indication of how everything has to be so precise for his care and his quality of life.

HARRISON: Well, the lady with the cap, what happened when she couldn't communicate?

MULLIS: She died. She smothered.

HARRISON: I don't have anything else of this witness.

SCHINDLER: Mr. Hepfer?

HEPFER: Mr. Myers, you mentioned his caregiver had to stop serving him?

MULLIS: She—I did not know her. Ms. Linda.

HEPFER: Would it be Ms. Lisa?

MULLIS: Oh, Lisa, I'm sorry. I'm terrible with the L's. She, she was not—when she had her injury she was not there and she had to have hip surgery.

HEPFER: And that, that caused some problems in the home and with Al?

MULLIS: That was a huge change. That was a huge change. I mean it's, you know, someone who's there that you know and are familiar with and all of a sudden they're not there. Yes, in my professional opinion.

HEPFER: (Unclear) to replace that person?

MULLIS: Again, that was the beginning of new people coming through and…

HEPFER: Unreliable people and some of that?

MULLIS: Lots of unreliable people, yes.

HEPFER: I think that's Ms. Lisa right behind you.

MULLIS: We haven't met.

HARRISON: That's a different Lisa.

MYERS: This is a different Lisa.

HEPFER: Oh, I'm sorry.

MYERS: Lisa too, yes.

HEPFER: Oh, okay, I'm sorry. I connected the names, I'm sorry. But anyhow that was, that was a fact during in the home situation and also in Al's grief situation.

MULLIS: Yes.

HEPFER: All right. But he had respite at some point, right, care as far as you know or do you?

MULLIS: I, again, I, I, began the case in August so you know before that I was only privy to comments when—through Ms. Myers so I'm not really sure. I can't really talk about it.

HEPFER: And also like Ms. Ray or Dr. Ray, you indicate that you think Al needs physical therapy or to potentially avoid hospitalization.

MULLIS: Absolutely.

HEPFER: And I guess that service is available under the State Plan as you probably heard.

MULLIS: I believe so, yes sir.

HEPFER: And he needs a speech generating device, you think.

MULLIS: Yes sir.

HEPFER: And that would be available under the Waiver, right?

MULLIS: Yes.

HEPFER: Okay, And he needs dental services, certainly.

MULLIS: Yes.

HEPFER: And that's another Waiver provided service.

MULLIS: Yes.

HEPFER: Psychological services certainly and you are engaged by the board through the Waiver.

MULLIS: Yes.

HEPFER: And nursing services. Do you know if there was a problem with nursing services or some kind of denial of nursing services?

MULLIS: With regards to?

HEPFER: To I guess with regard to whatever services were needed outside of the ADHC situation for example, tube feeding. Do you know anything about that?

MULLIS: I, I don't remember that Al had nursing services in the home.

HEPFER: All right, and you don't know whether that was requested or Ms. Myers requested that or…

MULLIS: I don't, I'm sorry.

HEPFER: All right. Do you know whether Ms. Myers was financially liable for the actions of the respite caregiver or do you know?

MULLIS: I don't know.

HEPFER: All right, thank you. That's all I have, no other questions.

HARRISON: The June 24th letter you've reviewed, do we have that, and did, did that request nursing services?

MULLIS: It did. It did.

HARRISON: And to your knowledge, were nursing services provided?

MULLIS: No, there were no nursing services in the home.

HARRISON: If, if those services had been provided with reasonable promptness when they were requested, would that have likely avoided institutionalization?

HEPFER: That's kind of a speculative question.

HARRISON: Well, she's worked with these folks for many years.

HEPFER: All right.

MULLIS: In my opinion, the specialization of nursing services would have been very beneficial to Al and to his mother that they would have been real consistency with nursing services than the entourage of PCA services. I still think that she, she needed the nursing services and she needed absolutely more PCA hours.

HARRISON: As opposed to respite hours?

MULLIS: Absolutely.

HARRISON: Now the Agency's saying we gave you respite instead and that's good enough.

MULLIS: No, no, respite does not perform the same job. Respite is more of a supervision. PCA is hands-on and Al requires and demands hands-on for cleanliness, the visual inspection for skin breakdown, he has to have his shoes taken off when he comes home, he needs to lie down when he comes home. I mean there's a lot of motion. Respite's not going to do that. That's not what they—that is not my understanding of what—that's not what I've seen out of a respite.

HARRISON: I had a question and I lost it. Okay. That's it.

SCHINDLER: Mr. Rick, were you all done?

HEPFER: Oh, no, I have no other questions of Ms. Mullis.

VOICE: May I leave?

SCHINDLER: Yeah, certainly. Anybody else…

HARRISON: I don't know if anybody else needs a bathroom break?

SCHINDLER: Is everybody okay? Ya'll need a break before we start the next person?

HARRISON: I'd like to call Lisa, please to the stand. Everybody's here, right? Okay.

SCHINDLER: Did we swear you in, Ms. Jones?

JONES: No.

SCHINDLER: I don't believe we did. So you do want Ms. Jones to testify?

HARRISON: Right.

SCHINDLER: All right. Will you please your right hand? Do you swear that the testimony you give in this hearing is the truth?

JONES: Yes I do.

SCHINDLER: And please state your name.

JONES: Lisa Jones.

SCHINDLER: Thank you. I may need you to move up here closer because it's kind of hard to hear you.

HARRISON: Ms. Jones, if you'd state your name for the record.

JONES: Lisa Jones.

HARRISON: Okay. And how do you know Al Myers?

JONES: I was his Personal Care Attendant.

HARRISON: Okay. And give me kind of a day in the life of Al or tell me, tell me what from, from and, and, to the extent you know about it, what kind of care did he need and how long did it take during the day?

JONES: Okay, basically, my morning starts six o'clock or seven o'clock in the morning.

HARRISON: If you'd speak up a little bit maybe.

JONES: Basically my morning starts out about seven o'clock in the morning. I have up until nine to get Al everything that he needs. I come in, wash him, first I kind of roll him around in the bed, get him moving so when we get ready to get dressed, he's flexed so that takes about twenty minutes in the morning. Get him up, wash him, hair, teeth, get him dressed, take him around in the kitchen. He's being fed, while he's being fed...

HARRISON: And his mom's feeding him.

JONES: Right.

HARRISON: How long does that process take?

JONES: His feeding takes from a good hour and twenty minutes for him to get it in and let it settle so I give it about a good hour and twenty minutes. While he's eating, I'm doing his room, preparing his stuff for his bag and stuff for him to go off to day care, well, not day care.

HARRISON: The nursing care.

JONES: Nursing care. Make sure he has everything he needs, his coat, stuff, shoes on. So that basically my morning takes me about two hours. By the time we get finished he's ready to go.

HARRISON: And then he goes to the Adult Day Health?

JONES: Yes.

HARRISON: And he's there during what hours?

JONES: From 9 to 2, 9 to 2:30.

HARRISON: Do you take him or does he get picked up?

JONES: He gets picked up.

HARRISON: Okay. Okay, then what happens at 2:30?

JONES: Well, I'm not there at 2:30. I'm PC so I come back in the evening hours at 6:30.

HARRISON: Now I believe you were there though on the day he came home from the workshop? Were you?

JONES: Now I might have been there some days if nobody is there to cover. I think those are respite hours but if nobody's there to cover since I live so close, I will come in and you know get him off the van or…

HARRISON: I understand that you normally don't do this. Kind of explain to us. Can, can he just get off the van and go in the house by himself?

JONES: No, he can't.

HARRISON: Okay, do they get him into the house?

JONES: No. They pull up the van. Most of the time I go out there and meet the van when he comes down, take him off, put him in the house, take him up to the kitchen area, get his clothes and stuff off. Check him over and see if he's got sticky fingers or face need wiping off, you know, just to relax, you know, for your, your day, your completion of your day.

HARRISON: Now if Al has a cold, can he wipe his nose?

JONES: No.

HARRISON: Okay. If he, if he has diarrhea, can he wait until a PCA got there three hours from now?

JONES: No.

HARRISON: What would happen if that occurred and the PCA wasn't there?

JONES: Basically he would have to sit there in it until someone gets there to change him.

HARRISON: Okay. So you, you, the PCA, not you but the normal PCA gets him off the van, into the house and then what happens?

JONES: Like I said, take his clothing off, check him, change him, let him lay down and rest for awhile.

HARRISON: And how long does that take by the time you get him—by the time the van arrives to the time you got him down on the bed?

JONES: He probably lays down about 4.

HARRISON: So that's an hour and a half?

JONES: Uh-huh.

HARRISON: Okay. Could mom go off to the grocery store then and leave him there if there wasn't a PCA there?

JONES: No.

HARRISON: Okay. So at 4 o'clock then he lies down and then what happens?

JONES: He'll lie there for a minute, relax, whatever. Usually he's back up, just to give him a break out of that chair for a few minutes to get himself together, he's back up usually by—he don't lay down no more than an hour, sometimes not even an hour.

HARRISON: So about 5 o'clock you need to have somebody there who can lift him?

JONES: Yes.

HARRISON: Okay.

JONES: Be about 5 o'clock after he's lifted and freshened up or whatever, take him for mom to feed him, while she's feeding him…

HARRISON: And how long does that feeding take?

JONES: Same amount of time. It takes…

HARRISON: An hour and 20 minutes?

JONES: …about an hour and 20 minutes.

HARRISON: Okay. And I'm assuming there's other things to do, laundry and…

JONES: Laundry, getting his stuff together for the next day for the center, make sure his bags are packed, make sure his little lunch bag is packed, make sure his clothes are clean. The majority of time lay out his clothes for the next day, have everything organized and ready. Mom has his stuff ready for his next feeding for the morning and just…

HARRISON: So the feeding takes until about 6:20 or 6:30?

JONES: Usually about 6:30.

HARRISON: Okay, and then what happens?

JONES: 6:30, okay he gets finished. He takes his medicine. Basically you're still doing like laundry and stuff like that, waiting really for his food to digest before you really move him around. Like I say getting his clothes ready

for the next day. Make sure his room's straight. Make sure he has everything. You do a load of clothes, you know, sometime you go straighten up his bathroom because in the morning you probably left a few things laying around and then probably about 8:30 almost 9 we start getting him ready and preparing him for bed.

HARRISON: Okay, and what does the preparation for bed—now how many times is he tube fed a day?

JONES: Four times.

HARRISON: And that's about an hour and a half each time?

JONES: Uh-huh.

HARRISON: Okay. Okay, and so can he get him—so what does getting him into bed entail?

JONES: Getting him in bed is getting his bed ready. Getting his wash stuff ready, getting his night clothes ready. When I'm actually getting ready to wash him, lift him up with the lift, I put him in the bed, wash and take his clothes off…

HARRISON: So he gets washed again in the evening?

JONES: Yeah, he gets washed twice.

HARRISON: So I'm assuming maybe because he can't sit on the toilet there's a need—a hygienic need for a second bathing.

JONES: Basically for just sitting still all day, probably sweating, and brush his teeth and make sure everything is clean.

HARRISON: How long does it take to brush his teeth?

JONES: That's funny. It depends on his mood. Sometimes 15 to 20 minutes.

HARRISON: Okay. And he has a clinch issue?

JONES: Yes he does.

HARRISON: So does that make it take longer or is it hard…

JONES: Yeah, you have to wait till he feels like he wants to open his mouth wide or he wants to give you a half a open. So sometimes we have to wait to see what he feels like doing.

HARRISON: If he only had four hours of PCA a day, could you count on Al be opening his mouth at 5:30 to brush his teeth?

JONES: No. And that's just like getting him dressed or anything like that. Basically you have to take your time because if his arm is sticking out and if he's not ready to move and stuff you have to wait until his flexibility gets there so I might have one arm in his shirt already and then I probably got to wait ten or fifteen minutes for him to try to get that other arm so I can get it in the shirt so basically it's how his body is working.

HARRISON: And are there some days it's more than other days?

JONES: Basically it's the same every day. It's not—you just have to wait until he's flexibility…

HARRISON: So when you say it's the same every day, every day you can expect to wait?

JONES: Yes.

HARRISON: Okay.

JONES: You just have to take your time and sometime I try to talk him into it, coach him, but it just okay, it's not working right now so well, yeah, it takes time.

HARRISON: Is all that voluntary or is some of it just involuntary?

JONES: It's involuntary.

HARRISON: Okay, and now with him, maybe you haven't been there long enough, if he doesn't have the PT services, does that make it harder? Can you talk about that?

JONES: It makes it real hard because even in the morning when he wakes up sometime, which I'm not a physical therapist or whatever, but I have to take time to rub his legs or maybe push him so he can relax I guess from laying in the bed all night and you know stiff, and I find it easier to dress him when, you know, if I move his arms and stuff around then, yeah.

HARRISON: And then so he goes to—what time does he go—after you get all this done, bathing and the tooth brushing and whatnot, what time is it by that time?

JONES: Basically about 9:30.

HARRISON: Okay. Okay.

JONES: Sometime I run a little bit later. Like I said it depends on how he's moving along.

HARRISON: Okay. If you would, would look, please at the PT evaluation for Al. And while she's looking at that I do need to make a bathroom run.

SCHINDLER: All right.

HARRISON: I don't know if anybody else does.

SCHINDLER: We'll pause for just a moment. We are back on the record.

HARRISON: So we've talked about Al's day. What other kind of things would not work on a schedule that Al needs, you know, like wiping his nose or is there any—anything else that happens throughout the day that you can think of other than what you've shared with us?

JONES: I don't think so.

HARRISON: Okay, okay. What would happen if he doesn't have somebody familiar with him?

JONES: Well, he gets along with just about anybody but it takes awhile. I don't even know how to answer that. I know one time we had an incident that I didn't come to work and nobody told him I wasn't coming and he just kept looking at the clock and looking at the door and everybody was trying to figure out what he was looking for but his mother figured it out. Nobody told him I wasn't coming so he basically knows, okay, who's supposed to be here, what time you supposed to be here and you're not here, so.

HARRISON: So he's familiar with his surroundings?

JONES: Yes, very, very.

HARRISON: Okay. Thank you.

HEPFER: Have you ever worked as a respite caregiver?

JONES: I have for about an hour, two hours.

HEPFER: Two hours. And who paid you?

JONES: The same company that I work for.

HEPFER: Let's see. He gets off the van from the ADHC about 2:30?

JONES: Yes.

HEPFER: He must be one of the first ones they drop off or the only one they drop off, something like that because if the day ends at 2:30 they would (unclear) at the ADHC?

MYERS: (Whispering) No, it ends at 2:00.

JONES: About 2:00, 2:00.

MYERS: Okay, well, it's about 2 o'clock.

HEPFER: He gets home about 2 o'clock?

JONES: Uh-huh.

HEPFER: And then what do you do from that 2 o'clock to the time to get ready for bed that is hands-on?

JONES: Okay, well most of the time I'm not there…

HEPFER: Who's there?

JONES: …because I'm a PC to respite.

HEPFER: Respite is there.

JONES: Uh-huh but if a respite doesn't show up for some reason then I'll come in…

HEPFER: Oh, I see.

JONES: And do it then.

HEPFER: In other words, respite usually is responsible for getting him off the van and so forth and getting him through till the time that you come to get him ready for bed. All right, okay. All right, and…

JONES: But if I'm there that time even though it is respite hours I still do what I do PC hours and just go ahead…

HEPFER: Sure.

JONES: …on and start getting him ready for his…

HEPFER: Do you get paid extra for that? Did you get paid for the respite hours?

JONES: (Unclear).

HEPFER: You work for an Agency, right?

JONES: Yes.

HEPFER: So why don't they just pay you for the respite hours that the other person missed?

JONES: Well, well sometimes, like I say I might have an hour or two that I will get paid for but you know if it's an emergency situation that somebody would have to come in, you know, they're not going to cover but so many hours that if it's not falling in the hours that it's supposed to be then they won't pay for it.

HEPFER: Okay. Do you know if Ms. Myers requested nursing services for the two feedings in the morning and the afternoon?

JONES: Yes.

HEPFER: What happened?

JONES: She didn't get it. I heard her say plenty of times you know because I'm not allowed to feed him so she has to feed him and if she has something to do okay, we're looking at each other, maybe I can feed him so we can—you know.

HEPFER: Do you know if she contested that decision? In other words if she complained about that decision?

JONES: Yes.

HEPFER: So you don't think she might have appealed that decision?

JONES: Now I don't know about all of that.

HEPFER: Okay. All right, okay. All right. The lift—how's the new lift working?

JONES: It works well. You want me to tell you exactly how it works but it works very well.

HEPFER: It works okay?

JONES: Yes.

HEPFER: For you, you're able to alone get him in the swing, up and down, also in the bathtub and so forth.

JONES: Now not the bathtub. It kinda take—it kinda take a little help with that bathtub like they say you have to…

HEPFER: The track is wrong.

JONES: Yeah, you have to position him.

HEPFER: You think the track is wrong?
JONES: I don't know if it's wrong or not.
HEPFER: It's not over the tub.
JONES: Well, maybe it's wrong then.
HEPFER: All right, okay. All right. I think that's all I have. Thank you very much.
JONES: Thank you.
HARRISON: Is Ms. Myers as strong as you are for lifting and…
JONES: No.
HARRISON: Okay. Are there things you can do that she can't do?
JONES: Yes.
HARRISON: Okay, is one of those things using the lift by yourself and…
JONES: Changing. Oh, I need to say yes instead of nodding my head?
HARRISON: Right.
JONES: Yes.
HARRISON: Okay. Now in order to get paid for respite, you have to take classes don't you from the DSN Board?
JONES: No.
HARRISON: Okay, do you—don't you have to be a certified respite provider?
JONES: No.
HARRISON: Okay, but I'm not talking about you, other people who do respite?
JONES: Oh, I don't know.
HARRISON: Okay.
JONES: But I don't think so.
HARRISON: Okay. Okay. That's all I have.
HEPFER: Okay, no other questions, Madam Hearing Officer.
SCHINDLER: All right. Ms. Harrison, have you got another witness?
HARRISON: I have Ms. Myers and I have known Ms. Myers…
MYERS: I guess the maybe's answered.
HARRISON: …for many years and we may be here, I told—explained to her we need to be short. Are we okay with…
MYERS: I'm her worst nightmare cause I talk too much.

HARRISON: ...staying late?

HARRISON: Are we okay with staying late?

SCHINDLER: We'll stay late but you know keep in mind that...

MYERS: I'm going to be brief.

SCHINDLER: ...it's your time as well as ours. Any of your other witnesses would like to leave, is that all right with you, Mr. Hepfer? Ms. Lewis...

HEPFER: I'm not planning on calling Ms. Lewis again but...

HARRISON: And I think Ms. Jones is riding back with Ms. Myers.

SCHINDLER: So you're stuck.

MULLIS: I've got a few more minutes so I'll just...

HARRISON: If you need to leave, is it okay for her to leave?

SCHINDLER: Well, we'd have to have an escort for you so you just need to let us know, you know.

HARRISON: So if you need to leave, let us know and maybe Ms. Lewis can take you down.

VOICE: Okay.

VOICE: (Unclear) take you down.

VOICE: My meter runs out at 7.

HARRISON: Oh, I think they quit at 6, don't they.

SCHINDLER: I think they stop like isn't it 5 or 6 they quit ticketing?

VOICE: I think it's 6.

HARRISON: Is it okay till 6?

SCHINDLER: All right, we'll move along quickly.

LEWIS: Well, if you can excuse me.

HEPFER: Yes I can.

LEWIS: I can escort you down if you'll let me go to my office for five minutes.

HARRISON: I don't think Lennie was ready to leave.

LEWIS: Okay, okay, okay, okay.

VOICE: So we'll...

LEWIS: All right, thank you. Ya'll have a good weekend.

SCHINDLER: Thank you, Ms. Lewis.

HARRISON: I'd like to call...

MYERS: I haven't been sworn in.

HARRISON: Yes you have.

MYERS: I was?

SCHINDLER: At the beginning of the hearing.

MYERS: Oh.

HARRISON: Because remember you said maybe.

MYERS: That's right. I said maybe. Okay.

SCHINDLER: But we can swear you again if you'd feel better about it. We'll just proceed.

HARRISON: Okay, you will tell the truth?

MYERS: I will.

HARRISON: Can you please state your name for the record?

MYERS: Carolyn Cooper Myers.

HARRISON: Okay. And tell me, Ms. Myers how you are related to Al Myers?

MYERS: I am his mother since December 4, 1977.

HARRISON: And how old is Al?

MYERS: Al is 34.

HARRISON: And how old are you?

MYERS: You would ask. I will be 70 years old in February.

HARRISON: Okay. And have you had some health issues?

MYERS: Mainly I have some degenerative spine arthritis and mainly back problems and the problem's on the right side and I don't know why it's the right side or right knee, right ankle, right thumb.

HARRISON: And what about, I believe there's some heart problems.

MYERS: No, not really. Chest.

HARRISON: Chest?

MYERS: Yes, congestion, bronchitis. I've had a lot of bronchitis.

HARRISON: Okay, and has that been a recurring?

MYERS: Yes, I have chronic bronchitis.

HARRISON: Okay. We heard earlier from the service coordinator that there's been no change. Has there been a change in your health since 2009? Has it deteriorated?

MYERS: Every year gets—my vision's a little worse, my joints are a little worse or something's a little worse.

HARRISON: So you have…

MYERS: Aging is not for sissies.

HARRISON: Okay. Now I think you wanted to share with the Hearing Officer, how long has Al been on the Waiver and how did that happen?

MYERS: Al was one of the first in the midlands area to get on the—Home and Commun—at that time it was called the Home and Community Based Medicare Waiver. My husband and I both lobbied the legislature to get the Waiver into South Carolina and Al was one of the first because we really, truly believed in keeping him at home and that was where the best place for him was and my husband died in 2004 from cancer and he died believing that we had the services that we would need to keep him at home as long as we could. And then all of a sudden four years after he dies and my, my second helpmate is gone, suddenly the services are all cut and so it's been very difficult to deal with, emotionally.

HARRISON: Okay. Prior to the announcement of these cuts, did you ever dream that Al would go into an institution?

MYERS: No, I really did not. I worked—my husband worked for ten years on the York County DDSN Board. I was on the York—on the Kershaw County DDSN Board for sixteen years and we even offered them my mother's home so that we could make a home for Al and we were turned down that they didn't want the home and they would not help staff it. So we've done everything we could to get—Al's been on the waiting list for placement in a community group home for probably ten or fifteen years now since he got out of high school.

HARRISON: Okay. And that wasn't offered to you?

MYERS: No.

HARRISON: I believe at one point you visited one of the regional centers. Can you describe for the Hearing Officer what the regional centers are like?

MYERS: That was when Dr. Buscemi became the Administrator at DDSN and they had the first meeting at Whitten Center and I was there because I was representing a group of parent advocates and what do you want to know about it?

HARRISON: Okay, just tell her what a regional center—how it's different from living at home.

MYERS: Good lord, it's everything in the world different from living at home. You are in a group where you have a roommate. You have people surrounding you in a day room all day long doing all sorts of things. But the biggest thing that was my concern that I saw was there were so many able-bodied people. In fact one of them grabbed Dr. Buscemi and pulled her out of the door and I'm thinking to myself as a mother, my son cannot defend himself from a fly that you know gets on his nose. So he would be defenseless among a lot of things going on around him. And that also proved to be true in the workshop when he was in Camden in the DDSN workshop.

HARRISON: Okay. When he was—when you were at the regional center, I believe they were showing you around and can you kind of describe that?

MYERS: Well, they had a tour planned for us, yes. And we got to see the new infirmary. It was lovely. We got to see where they have Sunday services or the chapel. I forget what else they had planned for us but I wanted to see because it had already come out that there would no longer be any community at home 24 hour a day respite and we had 52, one day for every week of the year we had 52 days of 24 hour respite and that allowed us to have someone to spend the night. I want to correct the record in that we have never had anyone that lived in. We had enough respite, 24 hours that when my husband was sick with cancer and we were having to take him to the emergency room and when my mother was sick dying with heart failure, that's where you may get the heart thing, and mother died

from COPD, and there were many nights when I would be called and have to get her to the emergency room and so when things were getting tough this one caregiver that we had for 18 years was sensitive enough, a unique angel that just fell into us from heaven, she was single, she was in her 40's and Al was—she loved people with disabilities and she loved to serve and she was very religious. And so she would stay. She had no obligations with family or sick children or anything like that so it worked. I don't...

HARRISON: Because you had those hours.

MYERS: Because we had those hours and it was 24 hour respite so if my husband—if I wanted—I got—we went to his class reunion and we went to my class reunion and she stayed for two nights so that we could attend class reunions. That is no longer an option at all in my life. I cannot be away from home. In fact, it's very difficult to even come to Columbia because the situation with whether a caregiver shows up at the door or not is always questionable.

HARRISON: The respite caregivers I believe are paid less than the PCA's?

MYERS: A lot, yes.

HARRISON: And was there more problems with those?

MYERS: Well, yes because...

HARRISON: Could you find respite?

MYERS: Well, it's like Lisa. Lisa was—started doing PC II and it was always sort of a slap in her face to have to do the respite hours if somebody else didn't show up to do them because she was mainly—she was doing the same thing but she was just making less money.

HARRISON: Now when you were at the regional center that day I believe you asked to see the building where the ICFMR respite would have been provided.

MYERS: Yes.

HARRISON: Was it like the rest of the...

MYERS: It was not planned for the tour but I asked in front of a large group of people if I could see the beds that would be used for respite, a community respite because I was told that if I got sick that's where Al would go and

so they said yes, after the finished the tour they would take me and then some other parents raised their hands and said they'd like to see it too. The floors were not polished. There were not mums lining the walkway and there were not pumpkins lining the walkway.

HARRISON: Like there were at the other places they expected you to visit.

MYERS: At the others that were on the tour, uh-huh.

HARRISON: Okay. Was it, when you went in was it—the environment different?

MYERS: There was a smell of urine in the unit that I entered where I saw all the kids and the things that were going on.

HARRISON: And that's where the ICFMR respite would have been provided…

MYERS: Uh-huh, and they had one young man I asked I said is there a young man here that would watch a Clemson football game or a movie? And I said who is the housemother and they showed me to the housemother and I went over and I asked her that question and she said oh yeah, Benjie or what—I don't remember now his name but she pointed over and he was in a glassed-off room. He was outside of the day room operations but he reminded me very much of my son because he had sort of some bent to his hands and the things that you get from cerebral palsy as you age and he was about the same age as my son. He had an augmentative communication device on his chair and I had to assume after that, they took me over and I just looked down at him and I said Benjie, you don't know me and I don't know you but I asked to meet you because, and he was looking at me sort of strange, which of course anybody would when a stranger walks up like that, and I said but I asked them if there was anybody who was smart here and they pointed you out to me and you should have seen his hands and his face light up. But he did have augmentative communication equipment. We also saw a beautiful physical therapy room and an occupational therapy room at the Whitten Center.

HARRISON: So if he went into an ICFMR would he be provided physical therapy?

MYERS: I'm assuming so since they have the setup for it. They employ…

HARRISON: And occupational therapy?

MYERS: They employ physical and occupational therapists.

HARRISON: And what about speech?

MYERS: Oh, they do like speech. It would have been a speech person to help put him in touch with that augmentative communication I would think.

HARRISON: Okay. Now, you asked at one point and I believe the letter is June 24th, did you provide this letter to the DSN board and ask them to provide you some nursing services?

MYERS: Yes, I went to Dr. Munn. She had been quite a supporter for both—she's my doctor and my son's doctor and asked her.

HARRISON: How long had she supported Al? How long has she I say supported, treated Al?

MYERS: We started with her right after my husband died so it…

HARRISON: Several years, she knows Al.

MYERS: Well, 2004.

HARRISON: And did she—what was her opinion about the need for nursing services?

MYERS: She said if you don't get this Carolyn, I don't know what you're going to do and she said I don't know how you're continuing to do what you're doing and I said well, I guess it's called love and she said well, I certainly don't have any hesitation in signing and I'm hoping and praying to get it. And I went back to her later and told her that I had not gotten it and that I needed to talk with her about alternatives because I had done everything that was humanly possible through advocacy and everything else to find something that would be available for my son when I was no longer able to take care of him or if I had to go to the hospital. And she said then we need to talk and that's how we came up with the nursing home in our area.

HARRISON: Okay, but, but the nursing services you needed to keep him at home were denied.

MYERS: Correct.

HARRISON: Okay.

MYERS: The house I offered to put him in was denied.

HARRISON: Okay. And let's talk a little bit about—it's been suggested that the workshop was another feasible alternative, did you find that the workshop was safe for Al?

MYERS: For a bit—for quite a bit of time it was, yes. But it deteriorated as the cuts came and the staff was trimmed. There was quite a bit of cutback in staff.

HARRISON: Okay…

MYERS: Al had a one on one when he first entered. He did transition from the school system. Al was also one of the first generation of kids to be able to go to school automatically. The laws for educating handicapped children were done in '75 and he was born in '77 so when he went to school they didn't know what to do with him and we've just been paving a few paths along the year, I'm tired.

HARRISON: So he had one on one services for…

MYERS: He had one on one services…

HARRISON: Before the cuts?

MYERS: I was on—Governor Carroll Campbell appointed me to the Disability Council and I was serving on there when we did a grant and wrote the School to Work Transition laws and so I was helping write it and it was also about the time when my son was going to be exiting school at age 21 so we applied it and we started working with the Board of Disabilities because that was the only option that we had for after school and we worked up a really, really good program. At that time Al had a communication device that he was using. At that time I was able to send the one on one aide to physical therapy with him and she was taught how to do range of motion and that was going on in the workshop.

HARRISON: But now up until about the time of these cuts, Al had a one on one at the workshop, is that right?

MYERS: No, no. No, no, No, no. That was cut back right before these cuts.

HARRISON: Okay.

MYERS: They were cuts that affected the boards even before that.

HARRISON: And is that when you started seeing problems? When he had a one on one at the workshop you didn't have problems did you?

MYERS: No, it was wonderful.

HARRISON: But after that one on one was taken away, is that when you started seeing problems?

MYERS: The biggest problem is when we started seeing we were having trouble keeping people trained that was how—why the equipment kept getting broke. It was expensive, augmentative communication equipment. It kept getting broke because we couldn't keep somebody trained to use it and so we just had to stop sending it and tried to use it at home only.

HARRISON: Now at the workshop, did they give him one of his feedings at the workshop?

MYERS: His lunch was given every day at the workshop.

HARRISON: And did they have a nurse?

MYERS: No.

HARRISON: Okay. And did you find that maybe they weren't doing it right, there was something about a pole.

MYERS: Oh, we had that especially adapted for Al's wheelchair. He's got a holder on it on the back with a pole that was made so that he could hold his feeding bag up there and then he would still be able to roll and go where he wanted to. But they—I taught them how to use that but the trouble we started getting into was you could train one person but then somebody else might be working with him another day and they weren't following through with training other people on everything.

HARRISON: Now…

MYERS: And obviously the day that he came home so wet, there were three days, they just weren't changing his pants as they should and I'm sure it's because they were short-handed. There's no doubt in my mind about it.

HARRISON: Okay, so you had trouble with him getting changed at the workshop and…

MYERS: No, only recently. Only in about the last three years.

HARRISON: After these cuts.

MYERS: Uh-huh.

HARRISON: Okay. Now but you were told there was somebody that wasn't a nurse at the workshop that was feeding him, right?

MYERS: Oh yeah, it was just aides.

HARRISON: But you were told that the respite worker couldn't feed him.

MYERS: Correct. At home.

HARRISON: And you were told that the PCA couldn't feed him, is that correct?

MYERS: Correct. Nobody could feed him but me or a nurse.

HARRISON: Okay. And what times does he get something through a tube either food or medicine?

MYERS: About 7:30 to 8 a.m.

HARRISON: It starts at 7:30 or 8?

MYERS: Uh-huh.

HARRISON: Okay.

MYERS: Well, it's according to how...

HARRISON: Well, just, just…

MYERS: According to how fast you can get him up and get his arms in his sleeves and all the stuff.

HARRISON: So you have to be flexible on that. Can you always make it start at that time?

MYERS: We have to pretty much if he's going to go to a day program. If the van comes then they don't wait over five minutes.

HARRISON: Okay. So he's fed in the morning, at lunch and then when else do you administer tube…

MYERS: Food?

HARRISON: Food or medicine through the tube.

MYERS: He basically eats—we set it up after he had his gastronomy to do it three times a day because he sat at the table with us and was able to have his meal while he ate and so he's used to three meals a day and then medicine at bed time.

HARRISON: And up until what, four years—when did Nettles die?

MYERS: 2004, December. Nine days before our 40th anniversary.

HARRISON: Before then it was two people helping him?

MYERS: Yeah, I had—and he had a wonderful father.

HARRISON: And you had the very dependable caregiver. Now what happened—you say she wasn't a live-in caregiver but because of those extra respite hours she spent a lot of time there, but what happened to cause her to not be able to work anymore?

MYERS: Yeah, I don't know where they came up with this thing about it being a lifter. She was not lifting Al. She was getting Al off of his van at the end of his workday when he was coming home and she went to turn and come up the little ramp that we have to get into our house and somehow, I don't know what happened. All of a sudden I just—luckily I was at home and I heard somebody yelling Ms. Myers, Ms. Myers, come quick, I need help. And I know that if she had not been holding on to the handles of my son's wheelchair she would have gone down. Well, there I was stuck with—and it was a hot day, no it was April, I guess it wasn't that hot but it just wasn't a day you wanted to—the sun was shining so I wanted to get out in but I couldn't get him until I could get her taken care of and luckily I still had some of my mother's handicapped equipment out in the garage and so I ran out and got my mother's rolling walker and she put—switched her hands from Al's wheelchair to that and I was able to take Al on in the house and then come back and help her get in.

HARRISON: Now after that injury happened wasn't there a question about whether she was doing respite or PCA at that time?

MYERS: That was the first call I got. First off, I called the center because I knew, having been on the Board, there was an emergency number and I just called and asked to speak to my service coordinator, Ms. Auker and I said Juanita, I've got an emergency. She said well, what is your emergency plan. I said my emergency plan was to call you. You got an emergency number and she said well, you have to have your own plan. And I said like what? She said well, you have to call on family members if you have

an emergency. I said well, I'm an only child, both my parents are dead and I said I've got a brother in law who hunts and fishes and plays golf. I don't know where in the heck he is and I've got a son that works in another county and I said I really don't have anybody to call on. And I've got two people I've got to see about and I thought maybe you would have another respite worker or somebody that could come out and she said no, we don't have any respite workers. We don't do respite anymore. I said oh, so Lisa's the only respite worker you have? She said yes. I said well, what do I do? And she said well call on your church friends and I thought I'm 70 years old. How many of my church friends do you think know how to take care of a totally handicapped child and tube feed him? So that was the answer I got. It kind of helped me on the road to knowing what kind of situation I might get into in an emergency.

HARRISON: And did you find that she was the last respite worker hired by—that was considered to be a board employee?

MYERS: She had worked for the board for 20 years when she had that injury. She had worked for us about 18 of those. They didn't count her first years because respite was just a program where they didn't employ them. That was when you were confused, that's when they had to go in during the day if they worked their job, they had to go in for five days a week and take off of their job to get qualified to do respite. And of course the parents were all saying well, they don't really want respite workers. They want to say they've got a service but they don't really want to provide. And…

HARRISON: Was there a question because of her status of whether she got Workman's Comp, was that denied?

MYERS: Worker's Comp was denied for her, yes. And that was because apparently a couple of weeks before her accident, they had called her in for a meeting and she said Ms. Myers I was so frightened the last time I had been called in by the boss for a meeting I was laid off and she said I was so afraid I was going to lose my job with Al and you know, she was just so devoted and she said but they said—the first thing that Mr. Warren told me was

Lisa, you have been such a good employee, you're never sick, you're never out, you've been such a help, but we're just going to move you because we want to preserve you as a respite person and let you—no, what she said, she said the only words I heard was he said, we want you to allow to be—continue to help the Myers' and Al and she said with that she just thought oh, thank you, God. And…

HARRISON: And she thought she was an employee?

MYERS: Right. Well, she was an employee. I've been—I was on the board. We gave an employee banquet every Christmas and I watched her get her service, 18 year service pin.

HARRISON: But was there a question about that when she was injured?

MYERS: Well, that's what they had done. When he called her in, what he went on to say that she did not understand but came out after her injury, and I had to call Mr. Warren to find out because I was concerned about her. I said I can't believe you're not getting worker's comp. She said well they tell me that they put me on a payroll of one. I said how can a big organization with all the employees they have have a payroll of one. She said I don't know but that's what Mr. Warren said that I would be on the payroll of one now. And that's why I wouldn't—I don't qualify for worker's comp.

HARRISON: So did they—was—did—was she able to go direct into rehab under worker's comp after her surgery?

MYERS: No, no, no. She was denied any benefits after she left the hospital except for a little bit somehow that was paid for by Home Health for about two or three weeks. And she—her family did decide to hire a lawyer and fight the—and they won so she has now gotten her worker's comp.

HARRISON: And if she hadn't won that lawsuit, would that not have placed your homeowner's policy at risk? If she couldn't have got…

MYERS: Well, if they had denied that she was an employee but now Mr. Warren had told me and he had told you, he told me twice at DDSN Board meetings and he had told you in your office, you told me that Lisa was going to remain an employee of the Board.

HARRISON: But they didn't pay the Worker's Comp because she wasn't.

MYERS: No, because they switched her to a payroll of one. She's still employed but she was on a different payroll because Worker's Comp says if you don't have more than 4 employees, you don't have to pay Worker's Comp. So they were just trying to skirt the law. And that's exactly what the lawyer proved when she fought it.

HARRISON: Okay. Have you…

MYERS: Now you see why they don't like me?

HARRISON: Okay. You have been involved in an advocacy group—tell me about the meeting—when did you first learn about these cuts?

MYERS: Another mother called me the morning that they were going to have the meeting in Richland Memorial Hospital December the, was it the 11th?

HARRISON: It was June, was it not?

MYERS: June 4, '09, June 4, '09.

HEPFER: Madam Hearing Officer, Ms. Mullis I think wants to leave.

SCHINDLER: Oh, I'm sorry.

MULLIS: I'm so sorry. Is it okay if I…

SCHINDLER: I don't have anybody to escort you down now is the problem.

HEPFER: Well, I can take her. We'll have to take a short break.

SCHINDLER: Yeah, we're going to have to take a break.

MYERS: Well, I'm about through.

SCHINDLER: We are back on the record.

HARRISON: I was asking about the meeting when families first learned about the cuts.

MYERS: And I was telling you that I was called by another mother from Elgin who said do you know about the meeting tonight? I said what meeting? No, I don't know anything about a meeting. She said well, they're talking about change—making some big changes on the Medicaid Waiver and some of the new Commissioners have demanded that they have something to inform the public and it's going to happen tonight and so I called another mother and I said come on and go with me. I don't know what's going on but I think we ought to go find out because I had helped to get her on—her

and her son on the Waiver. And we went and there was quite a crowd there. I was not expecting that large a crowd since I had just heard about it that morning but apparently word travels by parents and there were people from Charleston all across the State there but, but yet not nearly, not nearly the number of people they serve but the parents that were active and into things were there. And how much you want me to tell about that? You want me to tell about everything I heard behind me.

HARRISON: Had parents been aware before? Did you have any notice that they were changing the services of the Waiver?

MYERS: No, they were talking about a questionnaire that was sent out and I didn't really realize anything about it until it came out and they were saying that this is what we used to change the waiver and I had received one and I hadn't even bothered to fill it out because it was just saying which would help you more? This or that or the other and I thought I can't even decide which one.

HARRISON: Did it, did it tell you on that survey that that's the purpose to change the Waiver?

MYERS: Not a clue, no.

HARRISON: Okay. So did it appear that they were looking for input that night or what...

MYERS: No, it appeared they resented being there very much that night.

HARRISON: Okay, and did you speak out that night?

MYERS: Yes I did.

HARRISON: Okay, and what happened as a result of that meeting?

MYERS: Well, at the end of the meeting what—someone brought me the sheet where people had signed in and had their emails and addresses on it and they said we need to get in touch with these people and keep in touch. Well, it wasn't everybody that was there. It was just a small amount and I said at that time I was leading a newsletter and keeping in touch with the shag club and I said well I can email. So I basically went home and made a mailing list and started mailing these people just so they would know

because everybody wanted to know what was going to happen next because everything was up in the air. And I just started emailing people and I started going to the DDSN meetings to find out what was going on. And so when I would find out something or any information that I felt like another parent would like as much as I did I would email it to them and we started out with probably about 40-45 parents and we're up to about 600 now.

HARRISON: So you're kind of communication central for that?

MYERS: I was.

HARRISON: Okay. And what—how frequently did you send warnings out to families?

MYERS: Warnings?

HARRISON: Well, I mean...

MYERS: No, I always looked at it as sending information.

HARRISON: Okay.

MYERS: I wanted information. When I was on the DD Council and when I was more active in a lot of things, we were in Rock Hill and then we moved to Camden and I suddenly had to find new doctors and get—arrange for new people in the school system and a whole bunch of things and then my father died and then my mother started—I had to start going to help her some. So in the meantime I just sort of dropped out of real, real active advocacy and I was missing the information because once you're on a board or something you start getting something from everybody through the mail and I wasn't getting that much of it so I had never been to a DDSN commission meeting before and it was really quite interesting.

HARRISON: Okay, so you started attending them after that meeting every month?

MYERS: Most months, yes, for a good while.

HARRISON: But you hadn't done that before?

MYERS: No, I had not.

HARRISON: And were you disseminating that information to people across the State?

MYERS: If it was—yes, if I felt it was an interest to a parent.

HARRISON: And would you disseminate information about parents needing to appeal various things?

MYERS: Yes, oh yes. Yes.

HARRISON: So how frequently were you in touch with other family members across the State about these advocacy issues?

MYERS: Daily.

HARRISON: Okay. How many hours a day did you do that?

MYERS: I would always do it at night when the caregiver would come in at night to help out I would always have his food prepared during the afternoon and I would get a few hours, I would use my time from about 5 o'clock to 7 just to get on the computer and see if there were any emails I needed to answer or whatever most of the time.

HARRISON: While the PCA was there.

MYERS: Uh-huh, or once in awhile in the mornings if a lot was going on I would get on after Al left for his program and I would get on for an hour or so.

HARRISON: What did you—did you find that family members were involved in—we heard testimony that families were informed about this and they were involved. What did you find from your discussions with people around the State about the awareness of...

MYERS: Well, nobody knew anything that had been going on. Apparently they had been planning a year and a half that nobody knew about and suddenly we knew it and it was already almost a done deal. Families did get together and wrote CMS and in a large group and got it delayed. The approval was delayed.

HARRISON: And you—out of this did a group emerge?

MYERS: Yes.

HARRISON: And what's—what was the group that emerged out of this?

MYERS: We decided to name it South Carolina Voices.

HARRISON: Okay.

MYERS: At first we called it South Carolina Voices for the Voiceless but then we decided there was some—plenty that could talk.

HARRISON: And up until recently, did you hold an official position in that organization?

MYERS: I was not the first president but I was the second president and then when the caregiver broke her hip and everything I had to just sort of step back and somebody else took my place.

HARRISON: But that was after Al's services were cut. I'm sorry, let me withdraw that. I'm confusing things.

MYERS: Yeah, I'm confused too now.

HARRISON: Now when you talked to families around the State, did you—what did you—what impression did you get about their, their feeling about what would happen if they appealed?

MYERS: Well, there was a lot of concern there on my part too as well. Had I not known you I'm not sure I would have appealed because I kept getting a call from Ms. Auker saying that if we did appeal and Al's services would be continued during the appeal and if we lost the appeal, then I would have to pay all that money back and had I not talked with you and realized that wasn't true, she called me twice and told me that and a lot of other parents were being told the same thing, that they would have to pay the money back if they appealed.

HARRISON: That the parents would have to pay the money back?

MYERS: Yes, right.

HARRISON: Okay.

MYERS: And so I was trying to get the message out to parents that yes, you do need to appeal. Or if you feel like you're being threatened and it will hurt you, you can appeal but you will not have to pay that money back. The money is to your child and not to you and if they're an adult, you're not responsible.

HARRISON: What's—did you get any feedback throughout the State of how people felt about possible retaliation?

MYERS: People are very scared of retaliation. It's a very real fear among parents.

HARRISON: Did any people share with you examples?

MYERS: Yes. There are plenty of examples. There were three women from the Greenville area that, in fact I sat close to and met for the first time that June 9th, and they started emailing and calling and they had experienced retaliation because they had spoken out and complained about things. And they were actually calling to warn me that you are—you really shouldn't be doing this. And maybe I shouldn't have but I did.

HARRISON: Okay. What will happen to Al if—did anybody tell you that DDSN was coming out and they were going to do a PASRR evaluation and ask for input from you on what specialized services he would need in the community?

MYERS: No.

HARRISON: I mean, I'm sorry. Let me back—in the institution. Once he went to the nursing home, did anybody contact you and ask for input about what he would need?

MYERS: No, in fact I went to—only through you I knew what a PASRR was. I had never heard of it before in my life either because nobody mentioned it to me. I went to the nursing home director and asked her if she knew what it was and I said I think it had something to do with DDSN. She said well, they're a waste. She said those managers don't know what they're doing and she said we had never gotten any help from any of them so I didn't know, she did not know. She said I'd love to know if there's anything that would help.

HARRISON: Okay, and did—I'd like to call Counsel and the Hearing Officer's attention to page 3/31.

SCHINDLER: What are you looking at?

HARRISON: This document.

SCHINDLER: Okay, I think that is Petitioner's Exhibit 3.

MYERS: You should have called me the first in the morning when I wasn't tired and hot. (Laughing).

HARRISON: This is the PASRR evaluation. Did anybody ask for input from you about this evaluation?

MYERS: Who did this? Is this the person that did it that's down here at the bottom? Marcia Somebody? No, I know nothing of this.

HARRISON: Okay, let's look at the next page, the Reg's will show that the first page is done by the—the first PASRR I is done by the, by the nursing home and the page…

MYERS: Okay, all right.

HARRISON: …page, excuse me, let me see this, page 5 of 31, the individual whose name is there who did the Level II PASRR, did he contact you to ask you for input about what specialized services Al would need?

MYERS: This is his name down here, Brian A. Hawkins?

HARRISON: Right.

MYERS: He has his Master's. I don't know who it is. I've never heard of this person.

HARRISON: But he didn't contact you to ask what specialized services…

MYERS: No.

HARRISON: …Al would need?

MYERS: Uh-uh.

HARRISON: Okay, did DDSN, did your service coordinator inform you that if this PASRR evaluation needed—that said he needed specialized services that DDSN would have to pay for them?

MYERS: No.

HARRISON: So the service coordinator…

MYERS: You're the only person I've heard that from at all.

HARRISON: Okay. Do you agree with what's been said by Ms. Mullis and Ms. Ray about what would happen to Al if he doesn't get PT?

MYERS: I'm already working on it with the nursing home.

HARRISON: Okay. But they don't provide PT.

MYERS: No, that's what I found out.

HARRISON: Okay. Did your service coordinator tell you how you could get PT?

MYERS: I didn't bother to ask her.

HARRISON: Okay, but she didn't tell you…

MYERS: I'm sure she would have said you can't get it. There wasn't any point in calling.

HARRISON: Okay.

MYERS: That would have been a wasted call.

HARRISON: Okay. Did the service coordinator tell you how you could get—that it would be a feasible alternative to get an augmentative communications device through specialized services?

MYERS: No. No.

HARRISON: Okay. And the nursing home has told you that they won't pay for those things?

MYERS: Al hasn't been in there long enough now for us to even have a Plan of Care. We're just in the middle of discussing things and no, I haven't approached them with that. They've got enough to learn about how to feed him with a mic-key tube and all sorts of other stuff. I was in last night, called in at 7:30 because his button had come out and nobody knew how to put it back in so I went and put it back in.

HARRISON: Okay. So, excuse me, can I have just a minute?

MYERS: This whole thing is what has to be turned into PASRR, all of this?

HARRISON: I can't answer your questions while you're up...

MYERS: Oh, excuse me.

HARRISON: ...on the stand but I'll answer them later. I'll answer them later. Okay, did you try to get information to the service coordinator about what the doctor's opinion was? Did you give the service coordinator information about what the doctor's opinion was?

MYERS: You mean on this?

HARRISON: About the services Al needs.

MYERS: In the nursing home, you're speaking of?

HARRISON: No.

MYERS: No.

HARRISON: Prior to an—prior to all of this, did you, did you give her information about what the nurse—the doctor said that you needed? Prior to the nursing home?

MYERS: Yes, she had a copy of this letter.

HARRISON: Okay. And between what you told her that he needed and that, could she have surmised that he didn't need those services? Based on what you told her and based on the doctor told her?

MYERS: I guess she could have surmised anything she was told.

HARRISON: But was there evidence to support a decision that he didn't need that?

MYERS: She said Mr. Warren told her not to correct that.

HARRISON: So she told you the DSN Board…

MYERS: Executive Director.

HARRISON: Okay. Are you familiar with the band payments?

MYERS: Oh yes.

HARRISON: Okay. Tell me if he had been granted those services, who would have had to have paid for them?

MYERS: Wait now.

HARRISON: If he'd been granted the nursing services, who would have had to have paid for them when he was at home? When you asked for them in June with the band?

MYERS: I would assume the Waiver would have paid for them.

HARRISON: How would that have affected the Director who made the decision's financial situation?

MYERS: That would have been money out of their pocket. Although I was determined—I don't know whether there's any meaning to it now or not but I was determined to be an outlier of the banding system.

HARRISON: But his outlier status, did that change?

MYERS: I don't know. Nobody can find the paperwork on it. I asked the local board. They said they don't have the papers. We went through all sorts of stuff getting that done and then I have asked Dr. Buscemi and DDSN if

they can—they said they throw away stuff after six years so I haven't been able to get the paperwork on being an outlier.

HARRISON: Okay, but his current—his budget, do you know what his budget was at the time of the last meeting?

MYERS: I don't remember it. I'm thinking it was $58,000 or something like that.

HARRISON: Okay. Was he an outlier at the last meeting? Had he lost that funding?

MYERS: I couldn't find out.

HARRISON: But was he getting the funding that an outlier would get?

MYERS: I don't know what kind of funding an outlier gets.

HARRISON: Okay.

MYERS: I just knew I was on the county board and back then, they've cut this out but they used to have meetings at Myrtle Beach, conferences, and the Executive Director asked the board members if anybody would go because she thought the board members would learn a lot by going to their provider's conference. It was the provider's conference, so I went to the provider's conference and that was with a—I signed up for a thing that was called Explaining Band Funding and I didn't even know what it was. I thought they were going to start a band and here's the music or something and when I realized and heard it I realized they're starting something where they're putting categories of people here and the funding that they get is all going to be based on that and it didn't take me long to realize with my son's needs as large as they were, that somebody was going to be left out. It was either going to be him on the pious range or somebody at the bottom, he was going to rob money from and I didn't think it sounded like a fair system so I stood up at the end of the meeting and asked a question as you see, I figured they can't fire me. I didn't realize they would retaliate against me but I figured they couldn't fire me. So I stood up at the end of the meeting and I asked a question about in fact said just about what I did, you know, this doesn't seem fair, those—my son is very severely involved and if he's getting money out of the same pot as somebody who's less involved, then somebody's going to hurt in the

middle here somewhere and so, what's the—this gentleman came up to me after the meeting and he said can you step outside with me? And it turned out to be and I can't think of his name right now but Bill Barfield, is that—it's a Bill or Bob?

HARRISON: I can't answer your questions.

MYERS: ...anyway the gentleman whose name I cannot remember was the Head of Finance for DDSN and he came—he took me outside and he said go back home to your local board and tell them to make your son an outlier and I said okay. So that's what I did and he—we went through all the paperwork for him to become and outlier and all I could find out about it was that the board was given more levity. Al didn't have to fit into one of the bands, that they would be given more money because of how many outliers they had or something.

HARRISON: But since these cuts, did you find that Al's no longer an outlier?

MYERS: I can't find out. Nobody can find the paperwork. I've asked...

HARRISON: Nobody can tell you if he's an outlier or not?

MYERS: I keep saying is he still an outlier, is he still an outlier and I don't get any answers or any papers.

HARRISON: Okay, but his services have been cut.

MYERS: Oh his services have been cut regularly.

HARRISON: Do you feel differently now about the risk of a retaliation?

MYERS: Yeah. This particular instance right here where I was a member of four and there were some with the same needs that my son has and they were left out and then ours was contested, yeah, I think there's some retaliation going on.

HARRISON: The affidavit, I think we're submitted the affidavit of the treating physician, okay, if you'll take a look at that, is that an accurate assessment of Al's current medical needs?

MYERS: Pretty much, uh-huh.

HARRISON: Okay. How long has he been seeing—this is a doc—is this the same doctor that signed the June letter?

MYERS: Yes, yes.

HARRISON: Okay, so is this doctor familiar with his needs?

MYERS: Yes.

HARRISON: Okay. I think that's all I—is there, is there something you haven't—a burning desire to tell the Hearing Officer to help her understand?

MYERS: Oh, that's so dangerous. No, I won't do that, no. No, it's a long day and we all need to go home. I'll write a book one day.

HEPFER: Maybe I'll just wait for the (unclear).

(Laughter).

HEPFER: I guess I better not ask…

MYERS: I've been around the block. I mean, I don't know.

SCHINDLER: I know you must have a lot of…

HEPFER: Maybe I'll wait till the movie. Let's see. You used to get from…

MYERS: Oh, that's right, you've got to question me.

HEPFER: Yeah, I have questions. Just a couple to clear things up.

MYERS: No problem.

HEPFER: You used to get a couple of all day sessions maybe even once a week all day, someone would stay all day and that would be 24 hours, right? 24 hours of care.

MYERS: Yeah, 24 hours for $70.00 and I was shocked. In fact I can't believe, what was her name, Ms. Priest…

HEPFER: Uh-huh.

MYERS: …stood—sat there and said I didn't know anything about that rate because I stood up at the Commission meeting and made a speech about how could they justify taking—giving a family 24 hours of care for $70.00 a day and turn around and say we're taking that away from you and the only way you can get respite care now is to send your child to an institution, take them and drop them off. Well, now who's going to take their child to the institution and drop them off for one night to go to a reunion or something? It just makes no sense. But I said the thing that bothers me is that you were getting a bang for your buck for $70.00 for 24 hours and

now Medicaid is going to pay, was it $270, $270.00 for a day in the institution. So somebody was making money off of that.

HEPFER: So you don't think that you can get actually someone there to stay in the home, in-home respite for 24 hours?

MYERS: They won't—they won't—they, they, that was eliminated. That service was eliminated.

HEPFER: That wouldn't, that wouldn't just eat into your overall…

MYERS: It wouldn't—yeah, if, if, if this cut goes through and Al were remaining at home, this is what I had to analyze was could I—could we survive on 28 hours and I knew that we could not but if I use the 28—if I went out for 24 hours I wouldn't have any other hours for the rest of the week. And we were already running out of hours because everything was figured on a 30 day. There are 31 days in a lot of months and so we would—I would get a call from the agency saying you don't have any more hours for this month and nothing was figured in when they were figuring hours for me about the days that the center—the day center was closed for those six hours or if my son was at home sick and couldn't go to the center so I didn't have any hours to cover those days.

HEPFER: Okay. How did the—you had problems with the respite care providers?

MYERS: There just aren't many of them and in fact they have grandfathered with Nightingale Nursing who Lisa works for and I started getting our services from, they have only grandfathered me in because we were already with them. They are taking in no new people to give respite to because they aren't making enough money out of it doing it.

HEPFER: Things haven't been at all as reliable with—since Lisa fell, the other Lisa.

MYERS: Oh, no, no, no. She was an angel from God. I'll never replace something like that.

HEPFER: Tell me…

MYERS: But now this one came close.

HEPFER: When you tube feed Albert, what do you do? How does that work?

MYERS: We do—he has what they call a mic-key button…

HEPFER: Yeah, yeah.

MYERS: ...and that means that he doesn't have an extension tube hanging out of his stomach that you have to tape to the stomach. This is a newer device but yet he's had it since he was 12 years old but you can take the extension off and that's great. They're doing it for lots of babies and stuff now because they can crawl on the floor and get along and all that but we develop—we decided to do it by gravity because we wanted to do meals like a day and he would sit with the family and so the people that made his last wheelchair I told them I needed a pole so we could hang his gravity bag on it because I had been hanging it with a clothes hanger on the closet door or on the—you know, trying to put hooks around my house. Well, then we were stuck to wherever that hook was so they put on a piece of thing and made me a metal pole with a hook on it and we can now put it on his wheelchair and he can travel around the house and it's dripping with gravity into his feeding.

HEPFER: I see. So you fill up the bag.

MYERS: I fill up the bag, add water to it.

HEPFER: (Unclear)?

MYERS: Uh-huh.

HEPFER: All right. Okay. And you were requesting nursing services to do that, is that correct?

MYERS: Yes.

HEPFER: And the doctor said that if you didn't get them she didn't know what was going to happen.

MYERS: Well, it was not only that. We were talking about the fact that I could be cut back to 28 hours and...

HEPFER: Oh, I see.

MYERS: Yeah, I mean that was—that was, it was in appeal.

HEPFER: It was in appeal and...

MYERS: Right, right, there was an appeal pending and always that threat hanging over us that we might lose those hours.

HEPFER: Did you—did you by any chance appeal or ask for a reconsideration of the nursing hour denial?

MYERS: I don't believe I did. At that point I had appealed…

HEPFER: Did you talk with Mr. Warren about it?

MYERS: No, I only talked with Ms. Auker.

HEPFER: Okay what was the outcome of that conversation?

MYERS: She said that because we had moved Al from the DDSN Board to the Adult Day Health Program that had a nurse to do his tube feeding in the middle of the day that we couldn't have the—their regulation book said that we couldn't have any home nursing.

HEPFER: Even on the weekends?

MYERS: That's what she told me.

HEPFER: All right. So you want to have Al back home?

MYERS: I would have to think on that. Only in that if I was sick or had to have surgery whether that particular mode even if I could design it with the best of whether it worked for him now or not. And I'm not going to live—I'm not going to be around forever.

HEPFER: Yes, inevitable.

MYERS: It's always been in my mind that someday I would like to be a part of a transition for him so that I could see him happy and I could be a part of helping people know what his needs were and know something about him and I'm at that point now at age 70 and just kind of wearing out a bit and living under so much stress has been very difficult. I lost such a wonderful helper…

HEPFER: Right.

MYERS: …when I lost my husband and the I lost another good helper.

HEPFER: Ms. Lisa.

MYERS: Uh-huh, and then we had another good friend, he was a handyman and he was young and he died of a sudden heart attack just about five months ago so I mean I just keep losing people around me that were my supporters and that's been hard but I would do anything for—that son is like air I

breathe I love him so much. I love my older son too but he's able to do things on his own so I don't have to look out for him as much. Tell me your question again.

HEPFER: I said so you want him back home?

MYERS: Do I want him back home? Yeah. I also want to be younger. I also want to know what's going to happen in his future so.

HEPFER: Is he beginning to, I don't know, adjust to the nursing home at all?

MYERS: Yesterday was not a good day. They had tried something else and taken that pole and his feeding away and had him all hooked up on a I-V bag and it just took away his mobility and you know, it was not good and he didn't look happy. Lisa was there. That's how she got her invitation to come with me. I said you want to ride with me to Columbia tomorrow?

HEPFER: How about over the long term? How long has he been there?

MYERS: He's only been there about two and a half weeks.

HEPFER: Two and a half weeks. Good days and bad days?

MYERS: Yes. I'd have to say so. According to who's been trained and who's not.

HEPFER: Okay.

MYERS: And you know, they have substitutes and with it being the holidays we've probably had more substitutes and different things going on at that time because of that so I was understanding of that. There's some very good people that are working really hard to try to learn Al's needs but the biggest problem is that the situation is not appropriate to him because the next—he's 34 and the next youngest person is 74 so they don't like the same music he likes, you know. So he's getting most of his socialization from the staff.

HEPFER: On the other end, you wouldn't want to see him in an ICFMR I guess or is that a possibility?

MYERS: Well, I talked with Kathy Bradley, I've talked with a lot of people and she assured me and she brought one man over from Columbia that we had lunch together and she assured me and he did that they could set up something in the community where Al would be with some folks that were

not severely handicapped like he is because what he does at the workshop and at the other places, he enjoys the other people and they can actually be a help to him as long as they're—they might not be as smart but they're nice and loving and kind and they, they can—in the workshop they would let them roll his chair because they knew the ones they could trust and he knew the ones that he liked. One of them was a Sheriff all the time and he'd come over and talk to Al about how he was a Sheriff and he was going to arrest him if he didn't get a garnet wheelchair.

HEPFER: Would that be a kind of a residential habilitation type arrangement?

MYERS: Well, that's what I was told but, you know, that—Ms. Bradley is also the one that turned down my mother's home for our local board and I'm not sure at this point, I didn't think about it at the time but I'm not sure it got passed further up. I think Ms. Bradley might not have wanted to deal with something. She was getting close to retirement so I don't know.

HEPFER: Okay.

MYERS: But I know...

HEPFER: Well, I don't want—is...

MYERS: I just want you to sense of an agony of a parent who loves their child. The child did not come into this world to hurt anybody or anything. We have done as much as we can. I had to stop teaching because back in those days there were no day cares that would take handicapped children. I could probably be drawing retirement or have had a much better life but we love this kid and we thought that the State of South Carolina was proud of us because we were saving taxpayers a lot of money by keeping him at home.

HEPFER: On the other hand like you said, now I guess he's beginning to see that other people can take care of him too.

MYERS: Oh yes. Yes, yes. And that was good advice from an infant (unclear) person. She was a speech pathologist and she was at Winthrop College in my old freshman dorm which was unique. When we were back there and Al was six months old and I was desperately trying to find out what in the world cerebral palsy was going to mean and what we could do to fix it and

when we would go into the—for his therapy session I would sit there and there was another mother there with a teenage looking son and I had sort of started spotting people because the nurses—one of the nurses in the hospital had taken me around to show me different types of cerebral palsy and tell me what my son had and the bright eyes he had and she said I know my babies and your biggest thing you're going to have is the problem that's he got a brain and he can think and he can learn but he can't get it out and she said the spastics they can just jabber up a storm but they haven't got a thing in their head worth saying. And she proved it right. There was a brand new nurse and he was like 4 to 6 months old. Anyway, so I was very tuned to speech from the very beginning and but I asked the speech therapist, she had some ears on her and a lot of experience and every time I would be sitting out there with my son in my arms, this mother would go back with her son in a wheelchair and all of a sudden you could hear this gnashing of teeth. I mean it was just like—it was just like somebody was killing somebody and so finally I sat through that twice and I'm thinking is this what cerebral palsy is going to be? Is this the way my son's going to be when he grows up? And I went back and I asked this woman that I had come to trust her judgment and I asked her that question. Is this what Al's going to be like when he grows up and she said yes and it shocked me and she said yes, if you become a martyr to him. She said Al needs to know and I think she was telling me then that he would always be handicapped. I knew—I think I knew that but you know it was still early. But Ohe said you need to go out and you and your husband need to find sitters and you need to take breaks and live as normal a life as you can and let Al know that other people besides you can take care of him. And he is well adjusted to that fact.

HEPFER: Thank you ma'am. I don't have any other questions.

MYERS: Okay. We just can't find anybody to do it.

HARRISON: I don't have another question.

SCHINDLER: All right, I believe we're ready for closing statements then. Mr. Hepfer?