2014-002513

THE STATE OF SOUTH CAROLINA
In the Supreme Court

RECEIVED
DEC 4 2014
S.C. Supreme Court

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS
Case No. 2013-000762

Richard Stogsdill,.....Petitioner,

v.

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

Second Corrected Volume III
Orders and Briefs

Patricia Logan Harrison, Esquire
611 Holly Street
Columbia, SC 29205
803-256-2017
Attorney for Petitioner

Richard G. Hepfer, Esquire
Office of General Counsel
SC Depart. Of Health & Human Services
PO Box 8206
Columbia, SC 29202-8206
803-898-2791
Attorney for Respondent

PROTECTION AND ADVOCACY FOR
PEOPLE WITH DISABILITIES, INC.
Anna Maria Darwin, Esquire
Sarah Garland St. Onge, Esquire
3710 Landmark Drive, Suite 208
Columbia, SC 29204
803-782-0639

SOUTH CAROLINA LEGAL SERVICES
Kirby Mitchell, Esquire
701 South Main Street
Greenville, SC 29601
864-679-3247

SOUTH CAROLINA CHAPTER OF THE
NATIONAL ACADEMY OF ELDER LAW
ATTORNEYS
Philip J. Corson, Esquire
100 Stone Village Dr., Ste. 208
Fort Mill, SC 29708
803-746-7000

SOUTH CAROLINA APPLESEED
LEGAL JUSTICE CENTER
Stephen Suggs, Esquire
PO Box 7187
Columbia, SC 29202
803-779-1113

Attorneys for Amici Curiae

Index to Record on Appeal

VOLUME I

1. NOTICE OF APPEAL

ORDERS

1. Order of Carolyn Matthews, ALC, dated March 13, 2013 5
2. Order of DHHS Hearing Officer Bryson dated September 14, 2010 16
4. Order of DHHS Officer Loomis dated Nov. 16, 2009 31

PLEADINGS

1 Appellant's Reply Brief (ALJ) dated April 13, 2011 44
2. Respondent Initial Brief (ALJ) dated March 14, 2011 56
3. Appellant's Initial Brief (ALJ) dated Feb. 11, 2011 78
4. Respondent's Post Hearing Brief dated (HHS hearings and appeals) dated June 14, 2010 139
5. Respondent's Pre-hearing brief (HHS hearings and appeals) dated May 6, 2010 151
6. Appellant's Brief (HHS hearings and appeals) dated May 1, 2010 174
7. Respondent's Post Hearing Brief dated (HHS hearings and appeals) dated July 13, 2009 182
8. Appellant' brief (HHS hearings and appeals) dated July 7, 2009 195
9. Respondent's pre-hearing brief (HHS hearings and appeals) dated June 25, 2009 256

TRANSCRIPT OF HEARING, MAY 11, 2010

Preliminary matters 263

Respondents opening Statement 269

Petitioner's opening Statement 270

Respondent's case:

Dawn Shealy,- direct 275

Dawn Shealy- cross 278

Jacob Chorey- direct 291

Jacob Chorey- cross 294

Petitioner's case:

Nancy Stogsdill- direct 304

Nancy Stogsdill- cross 325

Respondent's closing statement 329

Petitioner's closing statement 329

Documents in Administrative Hearings

Respondents Exhibits 1 and 2 335

S. C. Supreme Court Complaint dated Dec. 23, 2009 337

SC HHS Internal Audit "A Review of MR/RD waiver as operated by DDSN", dated Feb. 28, 2006 434

VOLUME II

Protection and Advocacy, "Unequal Justice" 484

Protection and Advocacy, "No Place to Call Home" 561

LAC audit 641

Detailed Claim Report 747

Minutes of DDSN Commission 817

AARP 858

Minutes of the SC Budget and Control Board 875

Waiver Document Excerpts 891

Letter from Emma Forkner, SCHHS 895

Detailed Claim Reports 896

Letter from Andy Laurent 914

DDSN Letter to Cooper 915

Affidavits of Dr. Joseph, Richard Stogsdill and Lennie Mullis 917

Notices of Termination of Services 925

E-mail from Nancy Stogsdill 928

DDSN Annual Accountability Report 931

Notice of Appeal 933

Letter from Patricia Harrison dated Feb 11, 2010 938

Letter from DDSN dated January 12, 2010 940

2009 Documents

Letter to Buscemi requesting reconsideration of denial dated December 30, 2009 943

Letter from HHS dated November 16, 2009 .....

Appellants Letter requesting appeal dated Feb. 13, 2009 945

VOLUME III

1. SC Court of Appeals Opinion No. 5271, Sep. 10, 2014 948

2. SC Court of Appeals Order denying Respondent's petition for rehearing, Oct. 23, 2014 961

3. SC Court of Appeals Order denying Appellant's petition for rehearing, Oct. 23, 2014 963

4. Order granting motion to file amicus brief, Mar. 12, 2014 965

5. Appellant's Reply to Respondent's Return to Petition for Rehearing, Oct. 13, 2014 .. 967

6. Appellant's Return to Respondent's Petition For Rehearing on Issue of Whether Richard Is At Risk Of Institutionalization 979

7. Return to Appellant's Petition for Rehearing, Oct. 2, 2014 1056

8. Appellant's Petition Requesting Rehearing, Sep. 25, 2014 1061

9. Memorandum in Support of Petition for Rehearing, Sep. 23, 2014 1064

10. Memorandum in Support of Petition for Rehearing (Respondent's) 1175

11. Plaintiff's Reply to Respondent's Response to Brief of Amici Curiae, April 21, 2014 1180

12. Respondent's Response to the Amici Curiae Brief, Apr. 11, 2014 1319

13. Respondent's letter with supplemental cite and orders, Mar. 10, 2014 1344

14. Reply of Amici Petitioners to Respondent's Return to Petitioner's Motion for Leave to File an Amici Brief in Support of Appellant, Mar. 7, 2014 1359

15. Return to the Motion of Amici Curiae for Leave to File Amici Brief in Support of Appellant, Feb. 27, 2014 1365

16. Appellant's letter with supplemental cites, Feb. 26, 2014 1367

VOLUME IV

17. Amici Brief in support of Appellant, Feb. 21, 2014 1409

18. Final Reply Brief of Appellant, Aug. 11, 2013 1463

19. Brief of Respondent, Aug. 1, 2013 1493

18. Brief of Appellant, Aug. 10, 2013 1522

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

Appellate Case No. 2013-000762

Appeal From The Administrative Law Court
Carolyn C. Matthews, Administrative Law Judge

Opinion No. 5271
Heard March 12, 2014 – Filed September 10, 2014

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED

Patricia Logan Harrison, of Columbia, for Appellant.

Richard G. Hepfer, of South Carolina Department of Health and Human Services, of Columbia, for Respondent.

Anna Maria Darwin and Sarah Garland St. Onge, of Columbia, for Amicus Curiae, Protection and Advocacy for People With Disabilities, Inc., Amy Landers May, of Columbia, for Amicus Curiae, the South Carolina Chapter of the National Academy of Elder Law Attorneys, Kirby Mitchell, of Greenville, for Amicus Curiae, South Carolina Legal Services, of Greenville, and

Stephen Suggs, of Columbia, for Amicus Curiae, the South Carolina Appleseed Legal Justice Center.

KONDUROS, J.: Richard Stogsdill appeals the Administrative Law Court's (ALC's) order affirming the South Carolina Department of Health and Human Services' (DHHS's) decision approving the reduction in services to him. We affirm in part, reverse in part, and remand.

FACTS/PROCEDURAL HISTORY

Stogsdill is a Medicaid-eligible man receiving services under the South Carolina Intellectual Disabilities/Related Disabilities (ID/RD) Waiver (Waiver).[1] His mental capacity is normal, but because of premature birth, he suffers from significant physical disabilities that require aid in nearly every activity of daily living. Under the Waiver, the South Carolina Department of Disabilities and Special Needs (DDSN) beneficiaries can be provided a mix of services. Waivers permit eligible recipients to receive these services without the requirement of institutionalization. On January 1, 2010, the five-year renewal of the Waiver went into effect. The renewed Waiver included a cap or limit on some services and excluded others. DHHS administers the state Medicaid program and is responsible for the overall administration of the Waiver. DDSN is responsible for the day-to-day operation of the Waiver.

Prior to the Waiver changes, Stogsdill was receiving a combined sixty-nine hours of Personal Care Aide (PCA) and Companion Care services per week and approximately thirty-six hours of Respite Care per week. PCA services consist of hands-on personal care that the person needs to accomplish his or her activities of daily living such as bathing, toileting, dressing, and eating. Companion Care services are similar to PCA services but include an aspect of community integration. Respite Care can be a range of services, including personal care but is designed to provide services when the normal caregiver is absent or needs relief.

The Waiver capped any combination of PCA and Companion Care services at twenty-eight hours per week. The normal cap for Respite Services is sixty-eight hours per month, approximately sixteen hours per week, but exceptions can be granted for up to 240 hours per month, approximately fifty-six hours per week.

---

[1] This is the former Mentally Retarded/Related Disabilities (MR/RD Waiver).

Under these new limits, Stogsdill's services were reduced to twenty-eight hours per week of all PCA services, including Companion Care services, and sixty-eight monthly hours of Respite Care. After an application by his Service Coordinator, Stogsdill's Respite Care hours were increased to 172 hours per month. His occupational therapy and speech therapy were discontinued. Stogsdill appealed the reduction in services through the administrative process finally ending with the ALC affirming the reduction in services. This appeal followed.

STANDARD OF REVIEW

"The Administrative Procedures Act (APA) establishes the standard of review for appeals from the ALC." *Greeneagle, Inc. v. S.C. Dep't of Health & Envtl. Control*, 399 S.C. 91, 95, 730 S.E.2d 869, 871 (Ct. App. 2012), *cert. pending*.

> The court of appeals may affirm the decision or remand the case for further proceedings; or, it may reverse or modify the decision if the substantive rights of the petitioner have been prejudiced because the finding, conclusion, or decision is:
>
> (a) in violation of constitutional or statutory provisions;
> (b) in excess of the statutory authority of the agency;
> (c) made upon unlawful procedure;
> (d) affected by other error of law;
> (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
> (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-610(B) (Supp. 2013).

"Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. When determining whether the record contains substantial evidence to support an administrative agency's findings [the appellate court] cannot substitute its judgment on the weight of the evidence for that of the agency." *S.C. Dep't of Mental Health v. Moore*, 295 S.C. 42, 45, 367 S.E.2d 27, 28 (1988) (citations and internal quotation marks omitted). "Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence that, considering the record as a whole, would

allow reasonable minds to reach the conclusion the administrative agency reached in order to justify its action." *Fragosa v. Kade Constr., LLC*, 407 S.C. 424, 428, 755 S.E.2d 462, 465 (Ct. App. 2013) (internal quotation marks omitted).

LAW/ANALYSIS

I. Lawfulness of Reduction in Waiver Services

Stogsdill maintains the ALC and DHHS erred as a matter of law in concluding the 2010 caps were "lawful" based solely on the federal agency, Center for Medicare and Medicaid Services (CMS), approving them. Stogsdill contends the changes do not carry the force and effect of law because they were not passed as regulations pursuant to the APA. We disagree.

"'Regulation' 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).

> [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. When the action or statement so fills out the statutory scheme that upon application one need only determine whether a given case is within the rule's criterion, then it is a binding norm which should be enacted as a regulation. But if the agency remains free to follow or not follow the policy in an individual case, the agency has not established a binding norm.

Sloan v. S.C. Bd. of Physical Therapy Exam'rs, 370 S.C. 452, 475-76, 636 S.E.2d 598, 610 (2006) (citations and internal quotation marks omitted).

We agree with Stogsdill that DDSN has established a binding norm by reducing the types and amount of services offered under the Waiver. The record presents no explanation for the reduction in services to Stogsdill other than the cap put in place by the 2010 Waiver renewal. However, based on the relevant statutory scheme and

federal/state nature of Medicaid and the Waiver, DDSN was not required to pass a regulation to enact the cap as an enforceable provision.

South Carolina elected to participate in the Waiver Medicaid program in 1991. Pursuant thereto, the legislature created DDSN and designated it as the "state's intellectual disability, related disabilities, head injuries, and spinal cord injuries authority for the purpose of administering federal funds allocation to South Carolina." S.C. Code Ann. § 44-20-240, -270 (Supp. 2013). Federal regulations set forth the manner in which Waiver requests and renewals are made and approved. The governor, the head of the state Medicaid agency, or an authorized designee may submit the Waiver request. 42 C.F.R. § 430.25(e) (2013). The request is then reviewed by CMS regional and central office staff who submit a recommendation to the CMS Administrator. 42 C.F.R. § 430.25(f)(2) (2013). The Administrator may approve or deny waiver requests, and a request is considered approved unless, within ninety days after the request is received by CMS, the Administrator denies the request or sends the State a written request for additional information needed to reach a final decision. 42 C.F.R. § 430.25(f)(2)(i), (3) (2013). No one disputes the 2010 Waiver was so approved.

In *Doe v. South Carolina Department of Health and Human Services*, 398 S.C. 62, 70, 727 S.E.2d 605, 609 (2011), the Supreme Court of South Carolina considered whether Doe could be denied Waiver services because DDSN had concluded her mental retardation did not onset prior to her eighteenth birthday. The court concluded DDSN could not terminate Doe's services because the pertinent regulation required the onset of disability prior to age twenty-two. *Id.* at 72-74, 727 S.E.2d at 610-11. In discussing the ways DDSN may control the target population for Waiver services, the court concluded:

> In sum, it is clear that South Carolina *could have* listed additional criteria in the waiver application for the purpose of defining the population to whom it would provide waiver services. Likewise, DDSN *could have* promulgated regulations incorporating those additional criteria as part of the definition of mental retardation. But no such steps were taken. Rather, South Carolina adopted a broad definition of mental retardation in section 44-20-30, using language that parallels the [Supplemental Security Income] definition, and in Regulation 88-210, DDSN interpreted that definition in a manner consistent with the [Social Security

> Administration]. DDSN's interpretation of section 44-20-30 in its policy guidelines directly conflicts with Regulation 88-210 and should be disregarded.

Id. at 74, 727 S.E.2d at 611.

Additionally, in the dissent, Justice Hearn indicated "South Carolina can impose more restrictive criteria for mental retardation in its [W]aiver application or in a regulation." *Id.* at 75, 727 S.E.2d 612 (Hearn, J., dissenting). While the ruling in *Doe* was not dependent on a determination that approval of the Waiver renewal by CMS created binding law, it suggests the State may make changes to its program through that process.

Moreover, we find a case from the North Carolina Court of Appeals to be analogous and instructive. In *Arrowood v. North Carolina Department of Health & Human Services*, 535 S.E.2d 585, 587 (N.C. App. 2000) (*rev'd*, 543 S.E.2d 481 (N.C. 2001), NCDHHS sought a waiver from the federal government to implement its "Work First Program." *Id.* at 587. Under "Work First," a recipient signed a letter agreeing to a twenty-four-month limitation on public assistance. *Id.* After the twenty-four-month period expired, Arrowood sued arguing the limitation was not enforceable because it was not promulgated as a regulation under the state's APA. *Id.* at 587-88. The majority agreed, but the dissent was ultimately adopted by the North Carolina Supreme Court. *See Arrowood*, 543 S.E.2d at 481. The dissent determined the following:

> 42 U.S.C. § 1315 allows the Secretary of the United States Department of Health and Human Services (HHS) to waive requirements contained in 42 U.S.C. § 602 that pertain to state plans for Aid to Families with Dependent Children (AFDC) in cases of demonstration or pilot projects. On September 14, 1995, Governor Hunt formally submitted a request for authority to operate a statewide welfare demonstration project, entitled *Work First,* to HHS. In April [of] 1996 [,] HHS issued waiver authority to North Carolina to operate the *Work First* program. The waiver gave North Carolina authority to deny AFDC benefits to adults who had received AFDC for 24 months. North Carolina implemented the *Work First* program, including the 24-month time limit for benefits, in August [of] 1996. This waiver authority had

> the legal effect of superseding existing federal statutes that contain no such provision for time limiting benefits. G.S. 150B-19(4) prohibits an agency from adopting a rule that repeats the content of a law, rule, or federal regulation. The waiver authority cited above had the force and effect of federal law. Furthermore, it was sufficiently clear as to the provisions of the waiver authority. There was, therefore, no need for state regulation, and any such regulation would have been repetitive in violation of G.S. 150B-19.

Arrowood, 535 S.E.2d at 592-93 (Walker, J., dissenting).

Likewise, in this case, section 1915(c) of the Social Security Act, 42 U.S.C.A. § 1396n(c) (2012), enables states to request a waiver of applicable federal Medicaid requirements to provide enhanced community support services to those Medicaid beneficiaries who would otherwise require institutional care. *See also* 42 C.F.R. § 441.300 (2013) ("Section 1915(c) of the [Social Security] 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."). The State submitted its proposed Waiver, and it was approved by CMS. This Waiver authority had the legal effect of superseding existing federal statutes that would not allow for community-based services. The provisions of the Waiver are clear, and if "the State and the Federal regulations are not in agreement, the requirements of the Federal regulations shall prevail." S.C. Code Reg. 126-399 (2012). Based on all of the foregoing, we conclude approval by state regulation was not required to give the Waiver's provisions the force and effect of law. Consequently, we affirm the ALC's determination that the 2010 Waiver caps are lawful.

II. Notice and Due Process

Next, Stogsdill contends his due process rights were violated because he did not receive adequate notice of the reduction in services. We disagree.

42 C.F.R. § 431.210 (2013) address the content of notices regarding changes in the Waiver program.

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

(a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
(b) The reasons for the intended action;
(c) The specific regulations that support, or the change in Federal or State law that requires, the action;
(d) An explanation of—
(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Id.

In this case, precisely what notice Stogsdill received regarding the reduction in his services is unclear. The record on appeal does not include any notice, but the ALC's order indicates "a general notice was sent out to all DDSN clients notifying them of the *pending* changes and encouraged those affected to work with DDSN Service Coordinators (case managers) to mediate the impact of the new service limits." While such notice would fall short of the requirements of § 431.210, Stogsdill cites to no authority suggesting that this failure, in the absence of prejudice, requires any action. *See Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm'n*, 282 S.C. 430, 435, 319 S.E.2d 695, 698 (1984) (stating "proof of a denial of due process in an administrative proceeding requires a showing of substantial prejudice"); *see also Jones v. S.C. Dep't of Health & Envtl. Control*, 384 S.C. 295, 317, 682 S.E.2d 282, 294 (Ct. App. 2009) (finding the plaintiffs' due process claim failed when they received notice of the agency action enabling them to obtain a hearing before the ALC providing them the opportunities required by due process).

The record demonstrates Stogsdill has fully exercised his opportunity for a hearing and judicial review. As a result, we affirm the ALC's ruling that Stogsdill's due process rights were not violated.[2]

---

[2] While we observe Stogsdill suffered no prejudice in this case based on the inadequate notice of proposed changes, we do not condone DHHS's apparent failure to comply with 42 C.F.R. § 431.210 as this regulation is in place to ensure affected recipients have the fullest and fairest opportunity to exercise their rights.

III. Risk of Institutionalization

Having determined the 2010 caps were lawful and that Stogsdill's due process rights were not violated by the inadequacy of DHHS's notice, we turn to the question of whether the application of the caps to his case violates the Americans with Disabilities Act (ADA) as set forth in *Olmstead v. L.C. ex rel Zimring*, 527 U.S. 581 (1999). Stogsdill argues the ALC erred in finding his risk of institutionalization was "speculative" when it considered the reduction in his services. We agree.

In *Olmstead*, the plaintiffs were institutionalized women suffering from intellectual disability and mental illness. *Id.* at 593. They sought community-based care. *Id.* at 593-94. The United States Supreme Court concluded requiring the plaintiffs to be institutionalized and segregated from the population at large discriminated against them in violation of the ADA. *Id.* at 599-602. Therefore, treatment for disabilities is to be provided in the most integrated, least restrictive setting possible. *Id.* at 602 n.13; *see also* 28 C.F.R. § 35.130(d) (2013) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.").

A number of cases have followed in which Medicaid Waiver recipients protested the elimination of or reduction in their services, arguing the cuts put them at risk of institutionalization in violation of the ADA's integration mandate as interpreted by *Olmstead*.[3] *See M.R. v. Dreyfuss*, 697 F.3d 706, 734-35 (9th Cir. 2012) (granting injunction to plaintiffs opposing reduction in personal care hours as violative of the ADA and indicating "the elimination of services that have enabled [a plaintiff] to remain in the community violates the ADA, regardless of whether it causes them to enter an institution immediately, or whether it causes them to decline in health over time and eventually enter an institution in order to seek necessary care");

---

[3] We note there is some discord regarding the extent of the integration mandate in *Olmstead*. The controlling precedent for this case, *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013), is a 2-1 opinion wherein the dissent states, "North Carolina is not required to maintain any particular level of care to prevent the [plaintiffs] from entering an institution." *Id.* at 335 (Agee, J., dissenting). *M.R. v. Dreyfuss*, 697 F.3d 706, 734-35 (9th Cir. 2012) is also a 2-1 opinion wherein the dissent found plaintiffs failed to meet the burden of demonstrating their claims would succeed on the merits when plaintiffs were not facing immediate threat of institutionalization. *Id.* at 741-42 (Rawlinson, J., dissenting).

Radaszewski ex rel. Radaszewski, 383 F.3d 599, 614-15 (7th Cir. 2004) (reversing judgment on the pleadings in favor of agency when plaintiff had potential claim for disallowing twenty-four-hour nursing care that would allow benefit recipient to continue living at home); *Fisher v. Okla. Healthcare Auth.*, 335 F.3d 1175, 1181-82 (10th Cir. 2003) (holding cap on prescription drug coverage for plaintiffs in community-based Medicaid program did not require institutionalization as prerequisite for bringing ADA claim and claim was stated because plaintiffs would be denied service they could receive if they submitted to institutionalization); *but see Rodriguez v. City of New York*, 197 F.3d 611, 619 (2nd Cir. 1999) (denying injunction to plaintiffs seeking safety monitoring to remain in community setting and stating "*Olmstead* does not, therefore, stand for the proposition that states must provide disabled individuals with the opportunity to remain out of institutions. Instead, it holds only that 'States must adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide'").

The Fourth Circuit addressed this issue in *Pashby,* 709 F.3d at 321-325. Therein, the court affirmed the grant of a preliminary injunction that would prevent the elimination of in-home services to plaintiffs because that action placed plaintiffs at risk of institutionalization in violation of the ADA's antidiscrimination policy. *Id.* at 321-24. In concluding the plaintiffs established a sufficient risk of institutionalization to succeed on the merits of their claim, the court found interested parties in the case declared the plaintiffs "could not live on their own without in-home PCS [personal care services] or that it would be unsafe for them to do so. Each of these declarants also attested that the [plaintiffs] had no friends or family members who could offer the same amount of care that their aides provided under the in-home PCS program." *Id.* at 322. Additionally, all but two of the declarants indicated the plaintiffs "'may,' 'might,' 'probably' would, or were 'likely' to [face institutionalization] due to the termination of their in-home PCS." *Id.*

In this case, Stogsdill has provided the uncontradicted opinions of his treating physician, Dr. Thomas C. Joseph, and Lennie S. Mullis, a psychologist with DDSN, indicating the reduction in his services places him at risk of institutionalization. Both Stogsdill and his mother testified the reduction in services would place him at risk of institutionalization. This quantum of proof far exceeds that offered by the plaintiffs in *Pashby*.

Additionally, we recognize attending a sheltered workshop may be an option for Stogsdill that could substitute for some of the reduction in his service hours. However, the record reflects he will have little interaction with other individuals

who are not intellectually disabled, a situation that causes him great fear and anxiety. Furthermore, Stogsdill's physical limitations would place him in a vulnerable position with respect to other workshop participants who may not suffer from his level of physical disability, and it is unclear whether the required medical care would be available to him in this setting. Mullis attested a sheltered workshop would not be an appropriate placement for Stogsdill for psychological reasons, and Dr. Joseph agreed with her assessment.[4] DHHS has presented no probative evidence contrary to the conclusion that the reduction in services poses a risk of institutionalization. Based on the substantial evidence in the record, we reverse the ALC's conclusion that Stogsdill's risk of institutionalization was speculative.[5]

IV. Fundamental Alteration

Stogsdill next contends the ALC erred in concluding DHHS met its burden as set forth in *Olmstead* of proving that accommodating his needed services would force the State to fundamentally alter the nature of its program. We agree.

The *Olmstead* court recognized a state may have a defense to accommodating a Waiver participant's needs if doing so would present a fundamental alteration to its program. *Olmstead*, 527 U.S. at 603-04. "The reasonable-modifications regulation speaks of 'reasonable modifications' to avoid discrimination, and allows States to resist modifications that entail a 'fundamenta[l] alter[ation]' of the States' services and programs." *Id.* at 603 (quoting 28 C.F.R. § 35.130(b)(7) (1998)). In evaluating North Carolina's fundamental alteration defense, the *Pashby* court held:

---

[4] Mullis indicated "[a] combination of adult companion services, personal care services and respite services are needed to protect [Stogsdill's] health and welfare and to provide respite so that his parents can continue to provide support in his home to delay institutionalization." Dr. Joseph attested "[Stogsdill] would be at risk of institutionalization if the needed home-based services are not provided."

[5] As a subpart of his risk of institutionalization argument, Stogsdill contends the ALC failed to give Dr. Joseph's opinion the "greatest deference" required under Justice Kennedy's concurrence in *Olmstead*. Because we determine the record contains substantial evidence to support Stogsdill's risk of institutionalization argument, we need not address this issue. *See Futch v. McAllister Towing of Georgetown, Inc.*, 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999) (recognizing an appellate court need not address an issue when resolution of a prior issue is dispositive).

"budgetary concerns do not alone sustain a fundamental alteration defense. . . . We join the Third, Ninth, and Tenth Circuits in holding that, although budgetary concerns are relevant to the fundamental alteration calculus, financial constraints alone cannot sustain a fundamental alteration defense." *Pashby,* 709 F.3d at 323-24 (internal quotation marks omitted).

Our review of the record reveals no argument other than a general budgetary reduction and financial constraints as the basis for DHSS's fundamental alteration defense. Therefore, we reverse the ALC's finding that providing the requested services to Stogsdill would result in a fundamental alteration of the Waiver program. We remand this case to DDSN for an assessment of required hours and services without reference to the caps in the Waiver.

CONCLUSION[6]

We hold the caps included in the Waiver were not required to be promulgated as regulations to carry the force and effect of law, and Stogsdill was not denied due process by DHHS's inadequate notice in the absence of prejudice. Nevertheless, we find the substantial evidence in the record did not support the ALC's determination that Stogsdill's risk of institutionalization was merely speculative, and we conclude, under *Pashby*, DHHS failed to establish a fundamental alteration defense. Consequently, Stogsdill's case is remanded for consideration of the appropriate services to be provided without the restrictions of the 2010 Waiver. Therefore the order of the ALC is

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.

---

[6] Stogsdill makes a lengthy argument regarding the separation of powers in his brief. However, this issue was neither raised to nor ruled upon by DHHS or the ALC. Therefore, it is not preserved for appellate review. *See Staubes v. City of Folly Beach*, 339 S.C. 406, 412, 529 S.E.2d 543, 546 (2000) ("[A]n issue cannot be raised for the first time on appeal, but must be raised to and ruled upon by the trial court to be preserved for appellate review."). Additionally, we decline to address Stogsdill's remaining arguments regarding reasonable promptness and comparability as they are not necessary to the disposition of the case. *See Futch v. McAllister Towing of Georgetown, Inc.*, 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999) (holding an appellate court need not address any remaining issues if the determination of a prior issue is dispositive).

WILLIAMS and LOCKEMY, JJ., concur.

The South Carolina Court of Appeals

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

Appellate Case No. 2013-000762

ORDER

After careful consideration of Respondent's petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, Respondent's petition for rehearing is denied.

_____ J.

_____ J.

_____ J.

Columbia, South Carolina

cc:
Patricia Logan Harrison, Esquire
Richard G. Hepfer, Esquire
Anna Maria Darwin, Esquire
Sarah Garland St. Onge, Esquire

FILED
October 23, 2014
VGT

Amy Landers May, Esquire
Kirby Rakes Mitchell, Esquire
Stephen R. Suggs, Esquire
Jana E. Shealy
Peyre Thomas Lumpkin, Esquire
Heather M. Cairns, Esquire
The Honorable Carolyn C. Matthews

The South Carolina Court of Appeals

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

Appellate Case No. 2013-000762

ORDER

After careful consideration of Appellant's petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, Appellant's petition for rehearing is denied.

_____ J.

_____ J.

_____ J.

Columbia, South Carolina

cc:
Patricia Logan Harrison, Esquire
Richard G. Hepfer, Esquire
Anna Maria Darwin, Esquire
Sarah Garland St. Onge, Esquire

FILED

October 23, 2014

VCA

Amy Landers May, Esquire
Kirby Rakes Mitchell, Esquire
Stephen R. Suggs, Esquire
Jana E. Shealy
Peyre Thomas Lumpkin, Esquire
Heather M. Cairns, Esquire
The Honorable Carolyn C. Matthews

The South Carolina Court of Appeals

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

Appellate Case No. 2013-000762

ORDER

The motion for leave to file an amicus brief is granted. The amicus brief is accepted as filed. As announced during oral argument today, any response to the amicus brief must be served and filed by April 11, 2014. The Court will then consider the amicus brief and any responsive briefs pursuant to Rule 215 of the South Carolina Appellate Court Rules.

FOR THE COURT

Columbia, South Carolina

cc:
Patricia Logan Harrison, Esquire
Richard G. Hepfer, Esquire
Anna Maria Darwin, Esquire
Sarah Garland St. Onge, Esquire
Amy Landers May, Esquire

FILED
March 12, 2014

Kirby Rakes Mitchell, Esquire
Stephen R. Suggs, Esquire

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

Case No. 2013-000762

Richard Stogsdill,
Appellant,

v.

South Carolina Department of Health
and Human Services,
Respondent.

RECEIVED
OCT 13 2014
SC Court of Appeals

APPELLANT'S REPLY TO RESPONDENT'S RETURN TO PETITION FOR REHEARING

Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
803 256 2017
Attorney for Appellant

Richard G. Hepfer
Office of General Counsel
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, South Carolina 29202-8206
Attorney for Respondent

I. **Deference owed to treating physician.** DHHS argues in its Return that *Olmstead v. L.C.* only applies to persons who are already institutionalized. Respondent argues that the "greatest deference" mandate, requiring States to give the greatest of deference to the opinions of treating physicians does not apply to DHHS. 527 U.S. 581 (1999). This totally ignores nearly two decades of court decisions, interpreting the integration mandate of the Americans with Disabilities Act (ADA).[1] Furthermore, the South Carolina District Court in *Peter B. v. Sanford*, a case in which DHHS is a defendant, recognized the deference that must be given to the opinions of treating physicians. *Olmstead* at 610 and *Crabtree v. Goetz* at 2008 WL 533056 at *25. See R&R of Judge Bruce Howe Hendricks at pp. 8 and 22. http://www.clearinghouse.net/chDocs/public/PB-SC-0001-0007.pdf. The term "medical assistance" in 42 U.S.C. § 1396d(a) means:

> ...payment of part or all of the cost" of services like "home health care," and "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician...within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

In *Smith v. Benson,* quoting *Rush v. Parham*, 625 F. 2d 1150, 1155-56 (5th Cir. 1980), the federal district court held that:

> ...a state may adopt a definition of medical necessity that places reasonable limits on a

---

Helen L. v. DiDario, 46 F.3d 325 (C.A.3 (Pa.), 1995); *Martin v. Taft*, 222 F.Supp.2d 940 (S.D. Ohio, 2002); *Townsend v. Quasim*, 328 F.3d 511, 516-17 (9th Cir.2003); *Fisher v. Oklahoma Health Care Center*, 335 F.3d 1175 (10th 2003); *Radaszewski ex rel. Radaszewski v. Maram,* 383 F.3d 599 (7th Cir., 2004); *Jones v. Department of Public Aid*, 867 N.E.2d 563, 373 Ill.App.3d 184 (Ill. App., 2007); *Grooms v. Maram*, 563 F.Supp.2d 840 (N.D.Ill. 2008); *Smith v. Benson,* 703 F.Supp. 1262 (S.D.Fla. 2010); *Peter B. v. Sanford*, Case No. 6:10-cv-00767-JMC (D.S.C. March 7, 2011); *M.R. v. Dreyfus*, 697 F.3d 706 (9th Cir., 2012), *and Pashby v. Delia,* 709 F.3d 307 (4th Cir., 2013).

> physician's discretion in determining what services are appropriate in a particular medicaid case, although this does not remove from the private physician the primary responsibility of determining what treatment should be made available to his patients.

Supra at 1271. In *Rush*, the 5th Circuit explained that:

> We hold only that the physician is required to operate within such reasonable limitations as the state may impose. This same relationship between the private physician and government exists in the federal Medicare program, which, like Medicaid, is centered around the judgment of the private physician. 625 F.2d 1150.

In addition to ignoring the requirements of *Olmstead*, which requires state agencies to give the greatest deference to the treating physician, Respondent has disregarded the requirement that health insurers (in particular, State Agencies) must base determinations of medical necessity on the opinions of physicians, not lay persons who have no medical training.[2] Respondent's Return gives credence to Richard's fears that, if his case is remanded to DDSN, without this Court specifically requiring that medical necessity for Medicaid services must be determined by qualified health care professionals, DHHS will continue to give nothing but illusory weight to Dr. Joseph's orders, while failing to spend the funds allocated to provide services by the General Assembly. Judicial resources will surely be wasted if Richard's case is remanded again.[3] Respondent's Return demonstrates that the

---

[2] S.C. Code Ann. 40-47-20 defines the "Practice of Medicine" as (e) rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient ... and that (f) rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient is the practice of medicine subject to all of the powers provided to the Board of Medical Examiners, except as provided in Section 38-59-25. The record documents that DHHS routinely allows non-physicians to determine medical necessity and make treatment decisions in violation of this statute.

[3] These are state agencies that have consistently shown disregard for state and federal court orders. Since 2005, DHHS has refused to grant a hearing on the merits in *Peter Brown v. DHHS*, despite this Court unambiguously ordering DHHS to provide a hearing on the merits in 2011. 393 S.C. 11, 709 S.E.2d 701 (S.C.Ct.App. 2011) and *Peter Brown v. DHHS*, 13 ALJ 08-0159-AP, Feb. 4, 2013. This Court may take judicial notice of its own docket at 2014-000443, which documents that Peter still has not received the services at issue in that 2005 appeal. Despite the South Carolina Supreme Court directing DDSN and DHHS, in *Doe v. DHHS*, that the regulation promulgated by the General Assembly requires DDSN to apply an

agency will again base its determination of Richard's need for services on arbitrary and capricious agency policies, because DHHS continues to ignore federal law and federal court decisions with impunity. (The Fourth Circuit instructed SCDHHS and DDSN that "Once a state elects to participate in the program, it must comply with all federal Medicaid laws and regulations." *Doe v. Kidd I*, 501 F.3d 348 (4th Cir. 2007).) In this case, DHHS has even ignored the order of its own hearing officer, who chastised DDSN in the 2009 "fair hearing" decision for failing to obtain input from Dr. Joseph and failing to use "qualified individuals" who were "fitted (as by training and experience) for the care planning process." R. 37-41.

Respondent has refused to give the orders of waiver participants' physicians any real deference at all, while insisting that this Court should not require the agency to establish reasonable standards...or any standards at all. Instead, the record shows that all the agency and the Administrative Law Court have simply recited that DDSN considered the opinions of the

---

age 22 age of onset in determining eligibility for DDSN services, DDSN has flagrantly ignored that Court's order and several times revised the eligibility standards since 2011, thereby continuing to require applicants to prove onset by age 18. *Doe v. S. Carolina Dep't of Health & Human Servs.*, 398 S.C. 62, 727 S.E.2d 605 (S.C., 2011).*(This Court may take judicial notice of the SCLAC Audit of DDSN at* **http://lac.sc.gov/LAC_Reports/2014/Documents/DDSN.pdf** at pages 60-62, discussing this violation of the Supreme Court's order.) In 2013, the Director of the DHHS Office of Appeals and Hearings flat out refused to enforce the order of the Fourth Circuit in *Doe v. Kidd II, 2011* WL 1058542 (4th Cir. Mar. 24, *2011*) that required DDSN and DHHS to provide Sue Doe with residential habilitation services. *S.P. v. DHHS*, Appeals Case #05-MISC-025 (MR/RD) dated April 28, 2013(Exhibit 3 attached to Appellant's Petition Requesting Rehearing). Also in 2013, the district court noted that "The Fourth Circuit noted that Defendants still had failed to provide Plaintiff with residential habilitation services..." This was ten years after Doe filed her lawsuit in federal court. *Doe v. Kidd III,* Case No. 3:03-1918-MBS (D.S.C., August 21, 2013). Finally, DDSN and DHHS continue to refuse to provide services to B.W. that were ordered by Hearing Officer Elizabeth Hutto on November 19, 2013. *B.W. v. DHHS*, Case No. 07-MISC-028 attached as Exhibit 4 to Appellant's Petition for Rehearing. Even after B.W. filed a Petition/Complaint for Remedial Writ with DHHS and the South Carolina Attorney General, DHHS has refused to provide critical nursing services, as B.W.'s condition continues to deteriorate. See Exhibit 6 attached to Appellant's Petition for Rehearing. Justice delayed is justice denied, but in these cases, it is forseeable that justice delayed may result in death or other irreversible harm to vulnerable citizens of South Carolina.

treating physician - despite the record showing that this finding is just not true. Any "consideration" DHHS has given to the opinion of Dr. Joseph in this case has been illusory. Indeed, Dawn Shealy admitted that she did not review Richard's medical records or consult with his physician, and that she has no medical training. R. 278 to 288. Ms. Shealy did not even know whether Richard can get out of bed, dress, toilet or feed himself. R. 282.

It is obvious from the transcript of the hearing held in 2010 that, as in *Moore v. Cook*, that DHHS has based its determinations of medical necessity on "bureaucratic gobbledegook having no relation to (the participant's) actual condition or needs." Case No. 1:07-CV-631-TWT, 27 (Ga. D.C. April 19, 2012). As in *Moore v. Cook*: "The reduction in hours was arbitrary and capricious and was not based upon medical necessity." Id. That court found that the State had breached its duty to ensure that the services provided to the plaintiff were "sufficient in amount, duration, and scope to reasonably achieve its purpose." Id. at 27.

Respondent does not provide the Court with *any* authority supporting its interpretation and arguments on pages 1 and 2 of its Return. In *Olmstead,* at page 581, Justice Kennedy unambiguously held that:

> The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference...
>
> It is of central importance, then, that courts apply today's decision with great deference to the medical decisions of the responsible, treating physicians and, as the Court makes clear, with appropriate deference to the program funding decisions of state policymakers.

But, a review of the legislative history of the Medicaid Act reveals that long before *Olmstead*, the Senate reported that "[T]he *physician* is to be the *key figure in determining utilization of health services*—and ... 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 [legislation] would require that payment could be made only if a physician certifies to the medical necessity of the services furnished." (Sen.Rep. No. 404, 89th Cong., 1st Sess.(1965), reprinted in 1965 U.S.Code Cong. & Admin. News, p. 1986.)[3] In a pre-*Olmstead* decision, the Superior Court of Connecticut ruled that:

> ...the attending physician is the one who determines the nature and extent of the medical care provided at public expense based upon the medical needs of the indigent person 25 (pursuant, of course, to such reasonable regulations as are required for the efficient administration of this vast program).

Doe v. Maher, 515 A.2d 134, 144, 40 Conn.Supp. 394 (Conn. Super., 1986). And in *Katie A. v. Bonta*, the federal district court ruled that:

> The Medicaid Act does not define when a service is "medically necessary." Rather, the decision "rests with the individual recipient's physician and not with clerical personnel or government officials." *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir.1980); *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir.1989) ("The Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.").

433 F.Supp.2d 1065 (C.D. Cal., 2006). In this case, Richard has not asked this Court to give "uncritical discretion to the treating physician's recommendation" nor has he argued that Dr. Joseph's order is dispositive. But, after suffering through two "fair hearings" and months upon months of administrative delays, the State has utterly failed to produce <u>any</u> evidence at a hearing to suggest that Dr. Joseph's order is not reasonable, given the severity of Richard's disabilities.[4] It is burdensome to require Richard to endure yet another "fair hearing," before a

---

[4] 42 C.F.R. 431.244(a) requires States to base fair hearing decisions "exclusively" on evidence presented at a hearing. Richard believes that justice would be served if this Court were to consider only the medical evidence presented at the fair hearing.

third hearing officer whose agency obviously gives no regard to the Supreme Court's order in *Olmstead*, to the integration mandate of the ADA or to the Medicaid Act itself. This has been an agency that has historically acted as if it is above the law, without consequence.[5]

Finally, Respondent argues in its Return that "the treating physician's recommendations with respect to setting must be tempered by the State's discretion for program funding." An examination of "program funding" is thus in order. DDSN received at least $14.8 million in new state dollars for FY 2015, which will produce $45 million in new dollars to provide services, when matched with federal funds. Footnote 4 of Appellant's Petition. Not only that, but DDSN was caught by Governor Haley during FY 2014 holding an excess funds account containing more than $9 million. Id. See Governor's Executive Budget on page 237 at

http://www.governor.sc.gov/ExecutiveOffice/ExecutiveBudget/Documents/Executive%20Budget%20for%20Fiscal%20Year%202014-15.pdf.

The same month that the Governor's Executive Budget was released (January, 2014), DDSN informed its Commissioners that the South Carolina Budget and Control Board had advised DDSN to "hold" these excess funds to cover the costs of "a pending lawsuit." See http://www.ddsn.sc.gov/DDSNCommission/Documents/meeting%20minutes/01%20January%2016,%202014%20Commission%20Mtg%20Minutes.pdf. That is great news for Medicaid

---

5

Appellant calls this Court's attention to the 2008 findings of the South Carolina Legislative Audit Council, which found that DDSN spent must $7.6 million of the $25.4 million allocated to operate new beds, not counting the loss of the 70% match South Carolina lost in federal funds. Appellant's Petition for Rehearing at 22. That audit found that only $661,463 of state funds, out of $10.5 million, provided by the General Assembly for a new program to serve children with autism was actually spent for the intended purpose, again losing the federal match for every dollar not spent providing Medicaid services. Id. at 23.

waiver participants and their families who have struggled to keep their loved ones at home! Matched with federal dollars (70%), this excess funds account alone should produce $30 million in previously unaccounted for funds. Put together, this should provide DDSN with more than $70 million of new money to provide services to persons with disabilities. The relatively small amount of money DDSN would spend providing Richard the services he needs to remain at home, will be a drop in the bucket. Keeping Richard home should actually save state taxpayers money. Dr. Joseph opined that he has avoided expensive hospitalizations because of the care he has received at home and that his health would deteriorate in an institution. R. 920-922.

Respondent's claims that it must to "temper" physician's recommendations based on "program funding" concerns. That claim must be considered in light of the Comptroller's FY 2014 press release. That report documented that DHHS failed to spend a whopping $280,258,725 during FY 2014 alone. See page 4 at **http://www.cg.sc.gov/publications**and reports/Documents/Press/2014YearEndPressRelease.pdf. The Comptroller reported that the State of South Carolina's final net budgetary surplus of $266 million exceeded prior estimates by $32 million during FY 2014. These funds were placed in a "Contingency Reserve Fund," according to the State Comptroller. By the end of FY 2014, the State had accumulated an additional "Rainy Day Fund" of $293 million, apparently not counting the $117 million South Carolina held at the end of FY 2014 in Capital Reserve Funds. Providing Richard the services he needs could not possibly require DDSN or DHHS to fundamentally alter its programs to keep Richard at home. Anyway, we now know that the cost of the MR/RD Medicaid waiver (now ID/RD waiver) went UP when home-based services were cut in 2010. That year, the cost

of the program increased by more than $50 million over the amount CMS approved for the prior year. So, if these funds were to be appropriately spent, the citizens of South Carolina, disabled and non-disabled alike, should expect the cost of operating the ID/RD program to go down when the caps are removed and PT, OT and speech services are restored.

It will truly be a Great Day in South Carolina, when people like Richard will be given options to be fully integrated into the community, instead of being forced to attend isolated and warehoused in DDSN workshops during the day, where the "revenue" from their labors are paid to DDSN, to build up its "excess funds account."[6]

2. **Violation of Administrative Procedures Act.** Courts across the country have held that CMS approval of waiver amendments does not prevent courts from determining that waiver caps are illegal. *Crabtree v. Goetz, supra*; *Peter B. v. Sanford, supra; B.N. v. Murphy,* Case No. 3:09-cv-199 at 4.[7] In *B.N. v. Murphy*, CMS approved caps on waiver services and the

---

[6] Proviso 36.1 in the 2014-2015 State Budget for South Carolina provides that "All revenues derived from production contracts earned by mentally retarded trainees in Work Activity Programs be retained by the South Carolina Department of Disabilities and Special Needs and carried forward as necessary into the following fiscal year to be used for other operating expenses and/or permanent improvements of these Work Activity Programs." This is the slush fund that contained $7.8 million in September, 2009, when services to people like Richard were slashed due to contrived agency claims of budget reductions. Appellant's Petition at footnote 4. According to the Governor's Executive Budget for FY 2015, this DDSN "excess funds account grew by more than $6 million during the prior year. The Court may take judicial notice that DDSN's website contains a recent presentation by the Director of DDSN in which she admits that "The Day Program structure that currently exists in the SC DDSN system is given as an example of something that is not community inclusive." Exhibit 2 attached to Appellant's Return in Opposition to Respondent's Petition for Rehearing.

[7] In *B.N.*, CMS approved the cap, but the Court held that the cap violated the ADA and found that "no agency deference is appropriate with respect to statutes not administered by CMS." The court found that "no evidence before the Court suggests that CMS administers the Indiana ARPA, the ADA, the RA or Indiana Medicaid." Id. at 22. As in Richard's case, the

State Medicaid Agency failed to promulgate the changes as regulations under Indiana's Administrative Procedures Act. The federal district court held that "Such a cap meets the definition of a rule under Indiana law, is more than a merely internal policy, and, absent promulgation, is invalid." Id. at 8. ("The ...cap ... which was approved by the Department of Health and Human Services in 2008 has never been properly promulgated under Indiana law, and is therefore void." Id. at 9-10.) The court granted the plaintiffs' summary judgment due to the State's failure to comply with the provisions of the Indiana ARPA." Id. at 10.

Likewise, the majority ruled in *Jane Doe v. DHHS* that "Policy or guidance issued by an agency other than in a regulation does not have the force or effect of law." *Supra* and S.C. Code Ann. § 1-23-10(4). For the reasons set forth above, as well as those discussed in *McCrann ex rel McCrann v. DHHS,* Richard respectfully prays that this Court will reconsider its decision so as to require DHHS to promulgate regulations, declaring the reductions in services to be unenforceable and requiring that DHHS give the greatest of deference to the treating physician. 704 S.E.2d 899 (N.C. Ct. App. 2011).

3, 4 and 5. Violation of due process, reasonable promptness and comparability. Respondent argues that the comparability mandate is not applicable in this case, because DHHS obtained a waiver from CMS. Respondent is wrong. That waiver only allows DHHS to use more liberal income criteria and to waive that participants receive services in an institution. Richard clearly meets the definition of "categorically needy." As the South

---

plaintiff argued that the State Medicaid Agency had failed to provide CMS with "full information about the effect the cap would have on waiver enrollees." Id. at 23. Because the court granted declaratory and injunctive relief on other grounds, it did not make a ruling on whether the State violated the Medicaid Act by implementing the caps on services.

Carolina Supreme Court held in *Doe v. DHHS,* persons who receive home and community based services (HCBS) are a "defined subset of categorically needy persons."[8] Thus, 42 C.F.R. 440.240 clearly is applicable in Richard's case. DHHS must assure that the services available to any individual in the categorically needy group are equal in amount, duration, and scope for all beneficiaries in the group (in Richard's case, the ID/RD Medicaid waiver).

DHHS has assured the federal court that it has exempted the plaintiffs in *Peter B. v. Sanford* from the caps imposed on services in 2010. Thus, denying these services to Richard violates the comparability mandate. This issue is quite complicated and was not addressed in Richard's "fair hearing," because the decision in *Peter B. v. Sanford* came after that hearing.

Violations of Richard's rights to due process and to receive services with reasonable promptness have been ongoing and much of the evidence of those violations is not in the record before this Court. In addition, DHHS has refused to put into the record the transcripts and evidence presented at the 2009 hearing, thereby denying Richard's due process rights. In the federal court, depositions have been taken and the case is ready for trial in November. Richard suggests that it would "foster wise judicial administration and conserve judicial resources" for those issues related to due process and the Medicaid Act to be determined by the federal district court. Richard prays that the Court will deny Respondent's Petition and that the Petition of the Appellant be granted, as clarified herein. Richard requests a rehearing, if the Court deems appropriate, in the issue of violation of the Administrative Procedures Act.

8

The DHHS website states that "All persons applying for Medicaid must be categorically eligible. To be categorically eligible for Medicaid, an individual must be: receiving cash assistance such as SSI ... aged; blind; disabled;..." http://medsweb.scdhhs.gov/mppm/mppmtoc.htm. Richard is disabled and receives SSA cash assistance, thus he is "categorically eligible."

Respectfully submitted,

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

October 9, 2014

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

Case No. 2013-000762

Richard Stogsdill,
Appellant,

v.

South Carolina Department of Health
and Human Services,
Respondent.

APPELLANT'S RETURN TO RESPONDENT'S PETITION FOR REHEARING ON THE ISSUE OF WHETHER RICHARD IS AT RISK OF INSTITUTIONALIZATION

Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
803 256 2017
Attorney for Appellant

Richard G. Hepfer
Office of General Counsel
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, South Carolina 29202-8206
Attorney for Respondent

RECEIVED
OCT 0 3 2014
SC Court of Appeals

I. Introduction.

This Return is filed by Appellant, Richard Stogsdill in opposition to Respondent's Petition for Rehearing, pursuant to Rules 240 and 242 of the South Carolina Rules of Appellate Procedure. Appellant objects to Respondent's Petition, which challenges the Court's factual finding that Richard is at risk of institutionalization. The Court correctly ruled that *Pashby v. Delia* is controlling in this case and that Richard has demonstrated that he is at risk of institutionalization. 709 F.3d 307 (4th Cir. 2013).

To receive funds from the federal government for Richard's services, DHHS each year certifies to CMS that "but for the provision" of the Medicaid waiver services hard receives, he would require admission to an ICF/ID facility (formerly ICF/MR). R. 209. 42 U.S.C. 1396n(c)(1) provides that DHHS must show CMS that "but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan." *See also* 42 C.F.R. 435.217.

II. Respondent failed to produce *any evidence* from a qualified medical source at either hearing to rebut Dr. Joseph's determination that he is at risk of institutionalization.

42 C.F.R. 431.244(a) requires that fair hearing decisions must be "based exclusively on evidence introduced at the hearing." Despite having two opportunities at fair hearings, and having the home-court advantage of the hearing officer being an employee of the agency, DHHS failed to present even a scintilla of evidence at either hearing to contradict the determination of Richard's physician that he is at risk of institutionalization.[1]

---

[1] While this issue does not appear to have been addressed by appellate courts in South Carolina, other states have determined that when the Medicaid Agency terminates of reduces

Dr. Joseph opined that Richard's parents would not be able to provide for his care at home and that he "would be at risk of institutionalization if the needed home-based services are not provided." R. 921. Dr. Joseph provided specific evidence about Richard's condition and he explained why the services he ordered are medically necessary. R. 920-922. Richard's psychological services provider, Lennie Mullis, based her opinion on more than thirty years of experience working with persons who have disabilities, and her familiarity with the services provided through the program as a former director of a County DSN Board. R. 917. She stated in her affidavit that Richard's parents "are getting older and are not physically or mentally able to continue to provide care at the level they provided prior to his reaching age 21." Id. Based her experience in this system for more than three decades, Ms. Mullis opined that Richard's "mental and physical health would decline if he were required to attend a workshop" and that he would be "at risk of harm" due to the aggressive behavior of some workshop attendees and his inability to

---

benefits, the burden is on the State to prove that the participant is no longer eligible for the benefits. *Kegel v. State*, 113 N.M. 646, 648, 830 P.2d 563, 565 (Ct. Ap. 1992). See also *Simmons v. Van Alstyne*,65 A.D.2d 869, 410 N.Y.S.2d 400 (1978) (burden of proof when discontinuing benefits is on local agency, not petitioner, in first instance). In *In Re: Johnny M. Adger, Employee, v. City of Manning,* the South Carolina Supreme Court recently reversed the decision of the agency, because it improperly placed the burden of proof on the recipient of benefits. Appellate Case No. 2012-212722, No. 27424 (S.C. July 30, 2014). The Supreme Court held in another case decided in 2014 that when an state agency terminates a license, it is clear that the burden of proof is on the agency to justify the termination. *South Carolina Department of Motor Vehicles v. Brown*, Case No. 27346 (S.C.S.C. January 8, 2014). DHHS has failed to promulgate any regulation addressing who has the burden of proof in Medicaid fair hearings. When the State reduces Medicaid benefits, the burden should be on the State to prove that the change initiated by the agency was justified. The Director admits that the new CMS Final Rule (discussed below) "is a philosophical shift in that the burden is placed on the states to prove settings are integrated into the community." Exhibit 1. (This Court may take judicial notice of minutes of the DHHS CMS Final Rule Work Group located at https://msp.scdhhs.gov/hcbs/sites/default/files/CMS%20Final%20Rule%20Minutes%202-26-2014.pdf.)

defend himself." R. 918.

Respondent now asks that the Court ignore the opinions of these qualified medical professionals, who know Richard well and are familiar with his need for assistance with every single activity of daily living.[2] They are the persons to whom the United States Supreme Court determined the State must give the "greatest of deference." *Olmstead v. L.C.*, 527 U.S. 581, 610 (1999).

A review of the Record on Appeal, prepared by Respondent, reveals that DHHS failed to present any testimony or evidence from a qualified medical source regarding the risk of institutionalization. At the 2009 hearing, only DHHS counsel and Richard's service coordinator appeared on behalf of Respondent and the only exhibits Respondent presented were notices of hearing and the agency's prehearing brief. (According to the decision of Hearing Officer Loomis, the actual Record in those proceedings was omitted by DHHS.) Appellant presented live testimony from Nurse Todd and Richard's mother, along with uncontradicted medical records and an affidavit of Richard's treating physician, Dr. Joseph, into the Record. R. 31 and 32. None

---

[2] At the first "fair hearing" in 2009, Richard presented testimony from a nurse, David Todd, who had worked with him for years and was very familiar with his medical needs, but the hearing officer did not mention his testimony in her order or discuss the credibility of this witness. R. 31 and Exhibit 2 that was attached to Memorandum attached to Appellant's Petition for Rehearing. The hearing officer also accepted into evidence a letter from Rena Taylor, a physical therapist (R. 31), an affidavit of Dr. Joseph (R. 32), a two-page letter from Dr. Yajnik, a physical therapy prescription of Dr. Joseph, medical records of Dr. Lawrence Mauldin, an examination report of Dr. Kuzbary and progress notes from Camden Rehab (Id.). The 2009 decision of Hearing Officer Loomis was deemed by DHHS to be "interlocutory" and Richard was not allowed to appeal that decision. Respondent did not object to Richard's request to incorporate the 2009 proceedings into the record and the hearing officer reviewed and claimed to have considered the record in those proceedings. R. 14 and 68. Yet, he refused Appellant's requests to include this transcript in the Record on Appeal. R. 49-50 Richard argued that it was legal error for the hearing officer to omit from the record on appeal the transcript, exhibits and records in this proceeding and Richard's due process rights were violated thereby. R. 84-85, 93 and 97.

of this evidence supports Respondent's argument that Richard is not at risk of being institutionalized.

At the hearing in 2010, Respondent presented two witnesses and four exhibits. The first exhibit admitted at the 2010 hearing was a memo from its first witness, Jacob Chorey. This memo was sent by Chorey to the Director of the Office of Appeals and Hearings on February 18, 2010, without providing a copy to Appellant. R. 88. Mr. Chorey's *ex parte* memo lays out for the hearing officer the framework for the order DHHS sought. It does not provide an individualized assessment of Richard's condition or needs, or even address whether reducing these services would result in his institutionalization. Id.

Respondent's Exhibit 2 is the pre-hearing brief that was submitted by counsel for DHHS. R. 89. Therein, counsel makes legal arguments regarding the agency's interpretation of various federal mandates, but it contains no evidence that would support the agency's argument that this Court erred in making its factual finding regarding the risk of institutionalization.

Respondent's Exhibit 3 is a memo from DHHS' only other witness, Dawn Shealy. R. 97. It includes the assessment that was completed by Richard's DDSN service coordinator, Suzanne Yankovich, before Richard's father died. This assessment documents that Richard "Requires extensive, moderately intense support and supervision (within the same room or nearby, outside of visual supervision for 15 minute periods.") R. 98. The "caregiver stress" assessment prepared by DDSN supports the testimony of Richard's mother that she will be unable to sustain her efforts to provide care for Richard in the home without more supports and services. R. 99. It documents that Richard's mother "has back problems from lifting Richard and as she is getting older she does not have as much strength." Id. at 100. This assessment also documents that

Richard has no friends, neighbors, church members or extended family who can assist in caring for him. Id. It states that Richard's need for Speech Therapy, Occupational Therapy and Physical Therapy are not being met. Id. The DDSN Service Coordinator noted that Richard's family experienced loss of income and that caring for Richard has resulted in the loss of a job or reduction in hours worked outside the home. R 101. DDSN's own assessment clearly supports Dr. Joseph's opinion that Richard is at risk of institutionalization:

> Richard is non ambulatory and relies on the assistance of others to complete all activities of daily living and personal hygiene. Richard's parents are the primary caregivers and provide assistance to help Richard complete activities of daily living and hygiene tasks at the end of the day and throughout the night. Richard will call out to his parents during the night to go to the bathroom or if he does not feel well. Mr. and Mrs. Stogsdill have both had to alter their work schedules in order to ensure there is someone with Richard at all times.
>
> Mrs. Stogsdill has stated as she is getting older she finds it more difficult to transfers (sic) Richard easily and has back problems as a retult of years of transferring him. Mr. and Mrs. Stogsdill also care for elderly parents and are required to go to their residences, which are not local, to ensure that their needs are being met as well. Mr. and Mrs. Stogsdill have not been able to visit with family and friends or have a vacation for them as they need to make sure Richard is cared for. On the weekends, there is no support for Richard in the house so Mr. and Mrs. Stogsdill must ensure that one of them is home with Richard or take Richard wherever they go. Richard has expressed wanting to spend more time on the weekends with other people and be able to go out and do activities that are being held so that he can meet people his own age.

R. 102. On page 103 of the Record, the Service Coordinator stated that Richard needs "constant hands-on/direct care and supervision due to medically complex condition OR severe disability."

Ms. Shealy based her allocation of respite hours on a false impression that "Mom works part time." Ms. Shealy sent this assessment to Jacob Chorey, but there is no evidence in the Record that any qualified medical provider at DDSN or DHHS reviewed or provided input to the assessment. R. 108.

Respondent's final exhibit is a memo from DDSN employees to DSN Board Executive

Directors, and providers of service coordination and day services informing them that four meetings to be held in November and December. This exhibit has no bearing on whether or not Richard is at risk of institutionalization. Respondent's Exhibit 4. R. 110. The hearing officer included Respondent's Post-Hearing Brief as Respondent's Exhibit 5. R. 113. In this brief, Respondent's counsel argues that, on remand, Richard's case was "reevaluated and reauthorized by the local board, taking into account the orders of Dr. Thomas C. Joseph." R. 114. But there is no evidentiary support for this claim in the Record. It is totally unsupported by evidence *introduced at the hearing*, and only that evidence presented at the hearing may be considered. 42 C.F.R. 431.244(a). Counsel concludes at page 4 of the brief (R. 116) that it is speculative that Richard would be institutionalized, but absolutely no evidence is contained in the Record to support that argument.

Having established that Respondent provided no exhibits or documents at the hearing that Richard is not at risk of institutionalization, Appellant now turns to the testimony of Respondent's witnesses, Jacob Chorey and Dawn Shealy. Ms. Shealy admitted that she had no medical training. R. 33, and 41. Her testimony shows just how much attention she paid to the agency's assessment when she determined how many hours of respite care Richard was entitled to receive. The assessment contains facts supporting Richard's need for assistance with every activity of daily living throughout the day and night. Yet, even after preparing for her hearing testimony, Ms. Shealy still did not know whether Richard could get out of bed without assistance, whether he could toilet himself, feed himself, bathe himself or get out of the house in the event of a fire. R. 36. Contrary to counsel's arguments in the Post Hearing Brief, Ms. Shealy admitted in her testimony that she had not performed any review of the medical necessity for

Richard's services. R 34 and 35. She clearly and unambiguously stated that "I didn't review any medical records" and admitted that she had not communicated with Richard's physician. R. 36. She "just felt like 40 hours a week of respite was sufficient" because "The mother works part time." R. 38. Ms. Shealy was not aware that Mrs. Stogsdill worked six part time jobs or how many hours Mrs. Stogsdill works a week. R. 38. The decision about how many hours of respite care Richard would receive was based on "the assumption that the family would provide those services," in clear violation of 42 C.F.R. 435.602. R. 40.

Respondent's only other witness, Mr. Chorey, holds a Bachelor's in Psychology from BYU and a Masters in Counseling from Webster University. R. 45. He admitted having no involvement in the determination of Richard's need for services. R. 47. He also admitted having no "personal knowledge of Richard Stogsdill." R. 54. Mr. Chorey did not have a "full understanding" of Respondent's implementation of caps on services. R. 56. He began working at DDSN after the amendments to the waivers were implemented. R. 52. According to Mr. Chorey, his job "is to testify at these type of fair hearings to represent our Agency so even if I didn't have a direct role in the determination, I still would have a role in testifying to the processes that have been developed and any related information that I'm aware of." R. 55. Clearly, Mr. Chorey had no qualifications or experience that would allow him to determine the medical necessity of the services Dr. Joseph had ordered or whether Richard was at risk of institutionalization.

When the mandate of 42 C.F.R. 431.244(a), i.e. that hearing officers must base their decisions *exclusively* on the evidence presented at hearings, is considered, it is clear that this Court correctly determined that Richard is at risk of institutionalization. Richard himself provided a sworn affidavit stating that "Without the waiver services I need, I would have to live

in an institution." R. 924. Like Chip. E., in *Peter B. v. Sanford*, Richard is cognitively alert, but he has profound cerebral palsy and is dependent upon others for every activity of daily living. R. 130. As Judge Bruce Howe Hendricks recognized in that case it is "precisely for this reason, the prospect of institutionalization is most terrorizing to him." Report and Recommendation dated November 24, 2010 at R. 134-135. Richard's opportunities to participate as a valued member of the community, like those of Chip E., would be "forfeited upon institutionalization." Id. Judge Hendricks recognized in that case that:

> This is precisely the sort of injury incidental to the prejudice of segregation, which the *Olmstead* mandate contemplates and seeks to redress. *See Olmstead*, 527 U.S. at 60001 ("[C]onfinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.") His experience in an institution would come with all of the adjunct humiliations that violation of personal space and person imposes. "Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* Where such an experience can be avoided, without significant alteration of the *status quo*, the United States Supreme Court has stated, it should be.

Judge Hendricks also took note in her R&R of the audit of DDSN that had found "unsanitary conditions; abuse; neglect, and exploitation in these institutions" and the "irreparable harm and opportunity cost of a de facto involuntary institutionalization of a person otherwise content and healthy in the community." R. 135. She correctly determined that courts must give the opinions of the plaintiffs' treating physicians deference, citing the mandate of the United States Supreme Court in *Olmstead*, 527 U.S. at 610. Id. at 135. Judge Hendricks found that the "unfavorable resolution" of Peter B.'s administrative appeal was "additional evidence of the likelihood that the plaintiffs' rights in necessary services will not be protected and that they will be forced into institutional facilities but for Court action, now." Id. at 136. The district court

found that maintaining the plaintiffs' services would actually save taxpayer dollars and that granting a preliminary injunction "negligibly impacts" the State. ("In all respects, the undersigned believes that an ongoing violation of the ADA is present." R. 137).

In contrast to the "evidence" Respondent presented at the 2010 hearing in Richard's casee, he presented sworn affidavits from his treating physician and provider of psychological support services supporting his claim that failing to provide the services ordered by Dr. Joseph would lead to his institutionalization. It is important to note that Respondent did not object to these affidavits being received as evidence at the hearing. R. 268. Indeed, Respondent's counsel agreed to admit this evidence into the Record. R. 268, 312-313. The South Carolina Supreme Court recently ruled that a party in an administrative hearing waives his right to challenge the reliability of evidence entered into the Record at an administrative hearing if an objection is not made at the hearing. *S.C.D.M.V. v. Brown, supra.* As in that case, Respondent's after-the-fact objection to the admission of affidavits comes too late.

In any event, Rule 803(4) of the South Carolina Rules of Evidence provides an exception to the hearsay rule for:

> (4) Statements for Purposes of Medical Diagnosis or Treatment. Statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment; provided, however, that the admissibility of statements made after commencement of the litigation is left to the court's discretion.

Furthermore, DHHS' own website instructs waiver participants to bring medical records and letters from their physicians to the hearing:

Q. What Types of Evidence Can I Present at the Hearing?

Witnesses – someone who can help prove your arguments

Records – These can include any documents that show you meet the eligibility criteria such as income records, property records, medical records, or school records

Documents – These can include items such as income tax documents, bank statements, or a letter from your doctor

https://www.scdhhs.gov/site-page/appeals-and-hearings-frequently-asked-questions.

In its Petition for Rehearing on the issue of whether Richard is at risk of institutionalization, Respondent comes to this Court with unclean hands making arguments that hearing officers are prohibited from considering such evidence based on the hearsay exception. This attempt is made even more egregious by the fact that the live testimony Appellant presented at the 2009 hearing and the extensive medical documentation provided at that hearing was omitted by DHHS in the Record on Appeal, even though Hearing Officer Loomis' order was "interlocutory." R. 31 and 32. Richard's requests to supplement the Record with this wealth of information, obtained at great cost at the first hearing, were ignored by the hearing officer in violation of Richard's due process rights.

Respondent does not even attempt to dispute - or address in any reasonable fashion - the fact in its Petition that Richard requires around-the-clock care and supervision. The State failed to explain how, without subjecting him to settings his physician and provider of psychological services have determined to be unsafe, his need for assistance with activities of daily living could be met. The Court should deny Respondent's Petition for a hearing on the issue of whether Richard is at risk of institutionalization, as set forth in *Pashby, supra.*

III. The Court of Appeals properly interpreted controlling law in *Pashby v. Delia* in finding that Richard is at risk of institutionalization.

Having failed to present any testimony or other evidence at either hearing that supports

DHHS' argument in its Petition that Richard is not at risk of institutionalization, Respondent takes a shot at this Court's interpretation of *Pashby v. Delia.* 709 F. 3d 307 (4th 2013). But the Court's reliance on that decision is clearly supported, and nothing in Respondent's Petition changes that fact. *Supra.* In *Pashby*, the United States Court of Appeals for the Fourth Circuit ruled that a state must provide services to persons who have disabilities:

> " in the most integrated setting appropriate to the needs of qualified individuals with disabilities," *id.* § 35.130(d). Pursuant to federal regulations, the " most integrated settings" are those that " enable[ ] individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, app. B.

Id. at 321. The Fourth Circuit noted in that case that in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540 (1999), the Supreme Court ruled that "unjustified institutional isolation of persons with disabilities is a form of discrimination." *Id.* at 600, 119 S.Ct. 2176. The Fourth Circuit clearly shot down the State of North Carolina's "forceful" arguments" that the plaintiffs in *Pashby* were not likely to succeed because they had not been placed in an institution *yet.* Noting that the United States Department of Justice (DOJ) had already "refuted this argument," the Fourth Circuit dismissed that excuse for reducing services when those reductions might force people like Richard into group homes. Id. at 322.

The Fourth Circuit in *Pashby* recognized that DOJ has determined "the ADA and the *Olmstead* decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings." (Emphasis added.) U.S. Dept. of Justice, *Statement of the Department of Justice on the Integration Mandate of Title II of the ADA and Olmstead v. L.C.,* http:// www. ada. gov/ olmstead/ q& a_ olmstead. htm (last updated June 22, 2011); *see also Olmstead,* 527 U.S. at 597-98, 119 S.Ct. 2176.

Respondent's argument that Richard must not be at risk of institutionalization because he continues to live in his home for now is simply frivolous and it should be dismissed because Respondent has provided no factual support to refute the evidence Richard presented at the hearing.

Federal regulations prohibit the State from considering resources of the parents of an adult Medicaid participant in determining eligibility for Medicaid services. 42 C.F.R. 435.602(1) provides that "Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not consider income and resources of any relative as available to an individual." No reasonable person could argue with a straight face that Richard could remain at home without the resources that have been provided by his parents and the Medicaid waiver program. These parental resources, however, cannot be considered in determining his right to services or the number of hours he is entitled to receive, based on his own financial circumstances and his medical condition and needs.

Respondent's reliance upon services provided by Richard's mother, now the family's sole breadwinner working six part time jobs, clearly violates this unambiguous federal regulation. Only Richard's mother knows where her breaking point is. The State cannot determine where that point might lie or base Richard's entitlement to services on her continued gratuitous services, any more than it could require adult children to quit their jobs in order to provide care for elderly parents who meet eligibility requirements for Medicaid funded nursing home care or home and community based services. Forcing such obligation to care for another adult family member violates 42 C.F.R. 435.602 and it confuses the waiver participants *rights* with the agency's strong and unfettered desire to continue spending money allocated for services for

purposes unintended by the General Assembly. It is clearly discriminatory that DHHS would force parents of children with severe disabilities into making the Draconian choice of placing their children in unsafe facilities in order to obtain the services they need to live at home. R. 135. Yet DHHS has never been so bold as to suggest that able bodied adult children of disabled parents must quit their jobs, give up their lives and take care of their parents in their homes. Richard's right to services, without regard for what gratuitous services his mother might provide, is no less significant.

Respondent cites, but then ignores the ruling of the Tenth Circuit cited in *Pashby* that holds "there is nothing in the plain language of the regulations that limits protection to persons who are currently institutionalized." *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir.2003). Like those individuals in *Fisher* and *Pashby*, Richard has demonstrated that he would be required to enter an institution to obtain the Medicaid services he needs, thus he faces a "risk of institutionalization." The Fourth Circuit has now clearly held that group homes are institutions," for purposes of determining whether the State is in compliance with the integration mandate of the ADA. *Pashby* at 322-323. That Court noted that after DOJ conducted an investigation of whether North Carolina's group homes violated *Olmstead* 's integration requirement, the DOJ concluded in a July 28, 2011, letter that " [a]dult care homes are institutional settings that segregate residents from the community and impede residents' interactions with people who do not have disabilities." Id.

Respondent's attempt to distinguish Richard's case from *M.R. v. Dreyfus* also falls short of DHHS' target by a longshot. 697 F.3d 706. Richard's mother testified that he needs constant supervision to perform activities of daily living and instrumental activities that are provided by

personal care attendants and this testimony is supported by Respondent's own assessment of Richard's condition, the stress level of his parents (before his father died and his mother became the sole breadwinner and family caregiver), and his need for services. R. 159 to 169.

Like plaintiff C.B. in *M.R. v. Dreyfus,* it is uncontested that Richard "requires assistance with a range of tasks, including cooking, transporting herself (himself) to and from appointments with physicians, bathing and dressing herself (himself), and cleaning her (his) home. Id. at 729. C.B., however, was able to prepare meals in the microwave, a task Richard will never be able to accomplish. As with C.B., DHHS "did not respond" to the evidence Richard presented, in Richard's case, at two hearings. Also like C.B., Richard presented expert opinions that he is unable to participate in activities that "involve satisfying primary biological functions, this "[unmet] need cannot be tolerated for long." Id. at 730. The court ruled that C.B. "need only show that, by depriving her of access to care that is critical to her health, the regulation exacerbates the risk that she will be institutionalized." Id. at 731. Richard has made such a showing in this case.

The court determined that plaintiff K.S., like Richard, "requires assistance moving, bathing and dressing herself, cooking, managing her medications, using the toilet, and cleaning herself after accidents." Like Richard, if K.S. experiences incontinence while she is left alone, she must sit on the toilet until a provider arrives to help her undress, bathe, and launder her soiled clothes." (Actually, Richard would not be able to sit alone on the toilet, due to his spasticity.) Id. 731. Unlike Richard, K.S. is able to walk. Id. The federal court, however, found that K.S. is at risk of institutionalization because she is:

"worried that I would be unable to remain in my home ... and I very much want to avoid

> going to an adult group home. Staying in my home gives me a feeling of independence and I believe my mental health condition would deteriorate in an adult day home quickly. Even though I would be able to get more continuous hours of care at a nursing home, the lack of privacy and the lack of independence that I would experience there would be very difficult for me."

Id. at 731.

As to the reliance of declarations in *M.R.*, the federal Court of Appeals found that the district court had improperly "relied on an overly strict causation standard," just as Respondent attempts to do in this case by ignoring the affidavits Richard presented. The *M.R.* court ruled that beneficiaries of public assistance programs "may demonstrate a risk of irreparable injury by showing that enforcement of a proposed rule ' may deny them needed medical care.'" In *M.R.*, the appellate court recognized that like Richard, "individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, ... failure to make modifications to existing facilities and practices, ... [and] ... segregation," *id.* § 12101(a)(5). That court held that:

> In an attempt to remedy society's history of discriminating against the disabled—discrimination that included isolating, institutionalizing, and segregating them— the ADA provides that " no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." *Id.* § 12132; *accord* 29 U.S.C. § 794(a). The Department of Justice has promulgated regulations implementing the ADA. *See* 42 U.S.C. § 12134(a). One of the regulations is the so-called " integration mandate," providing that " [a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The " most integrated setting" is the one that " enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." *Id.* Part 35, App. B (2011). The regulation also provides that " [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." *Id.* § 35.130(b)(7).

Id. at 733-734. The Seventh Circuit clearly held in *M.R.* that the lower court erred in requiring the plaintiffs to "show that institutionalization is " inevitable" or that she has " no choice" but to submit to institutional care in order to state a violation of the integration mandate." Significantly, that court held that "[I]mminent risk of institutionalization is not required." Rather, "[t]he elimination of services that have enabled Plaintiffs to remain in the community violates the ADA." Id. at 734.

This Court correctly applied *Pashby* and *M.R.* to the facts of this case and determined that Richard is at risk of institutionalization and Respondent's Petition for Rehearing should be denied.

IV. **Respondent's Argument that Richard Should Submit to Services in Congregate Setting is Frivololous and it Ignores the Integration Mandate of the ADA.**

Respondent's arguments that Richard failed to show risk of institutionalization because he has not simply accepted the agency's scheme and subjected himself to the risks inherent in attending a workshop or receiving respite services in an ICF/MR demonstrates not only insensitivity to his needs, but also a complete disregard for the opinions of his treating physician and psychological services provider who have both determined that these settings would be unsafe for Richard. These arguments support Richard's Petition requesting that this Court determine based on the evidence Richard has already presented that he needs the number of hours his physician has ordered - without remand back to the agency, where Richard will surely cycle through with the same end result for the third time. There is no reason to believe that giving DHHS a third bite at the apple will produce any different or any more equitable results. DHHS has demonstrated in the past that it has no respect for orders of appellate courts, or any attempt to comply with the federal law.

In *Doe v. DHHS,* the South Carolina Supreme Court ruled that DHHS must apply an age 22 onset criteria for a diagnosis of mental retardation and that the age 18 criteria used in determining eligibility for the waiver program violated state law. 398 S.C. 62, 727 S.E.2d 605 (S.C. 2011). This Court may take judicial notice under Rule 201 that three years later, DHHS and DDSN continue to apply the age 18 requirement, in open defiance of the Supreme Court's order, without regard for the consequences to the lives affected by this illegal practice. See LAC audit of DDSN at page 59. http://lac.sc.gov/LAC_Reports/2014/Documents/DDSN.pdf.

In *Peter Brown v. DHHS*, this Court ordered DHHS to provide a fair hearing on the merits of his claim, yet two years later, DHHS dismissed his appeal without providing a hearing and Peter Brown still has not received the services that were wrongfully terminated in 2009. 393 S.C. 11, 709 S.E.2d 701 (S.C.App. 2011). This Court may also take judicial notice of its own docket at 13 ALJ 08-0159 at http://ctrack.sccourts.org/public/caseView.do?csIID=56094, which documents that these services still have not been provided to Peter nearly nine years after he requested a fair hearing, nor has he been provided a hearing on the merits ordered by this Court.

In *Myers v. DHHS*, DHHS led the Administrative Law Court to believe that therapies and a speech device could be obtained through another DHHS funding source other than the Medicaid waiver. Case No. 2014-00048. Yet, years after Myers lost his battle to remain in his home, the physical therapy, speech therapy and needed durable medical equipment promised are still being denied and he remains entangled in litigation with DHHS. (This Court may take notice of its own docket at *Myers v. DHHS*,http://ctrack.sccourts.org/public/caseView.do?csIID=56069)

Any reasonable person reviewing Dr. Joseph's affidavit could not arrive at any conclusion other than that Richard is at a seriour risk of institutionalization if he is not provided with around

the clock care. Respondent argues that his risk of institutionalization could not be "serious" because his mother could not imagine him being admitted to an ICF/ID facility to receive respite services. Must the mother of a soldier imagine her son in a casket in her mind before the serious risk of harm in battle becomes real? Will a mother's imagination make him more safe or more at risk, based on what she thinks in her mind? Whether or not a parent can "imagine" such a nightmare, does not in any way affect the severity of the risk. The right to receive services at home is Richard's right, whether or not his family members can bring themselves to imagine what might happen to him if he should lose his battle and be admitted to a DDSN ICF/MR or other congregate setting.

Respondent's argument that Richard is not at risk of institutionalization because his mother "could not imagine" her son in an ICF/MR is preposterous. There is nothing in the federal statute or laws that allows a State Medicaid Agency to base its allocation of services on what a parent imagines.

Respondent's argument that Richard's qualified professional medical sources do not use the words "serious of significant risk of institutionaliation" plays on words and totally ignores the evidence presented at Richard's two hearings. It is significant that, despite two opportunities, DHHS presented not even a single witness who was qualified to assess Richard's medical needs. DHHS omitted the transcript and exhibits from the first hearing, where Richard presented the live testimony from a nurse and extensive medical records. Exhibit 2, Affidavit of Nancy Stogsdill that was attached to Corrected Memorandum in Support of Appellant's Petition for Rehearing and R. 31-32. The Court should deny Respondent's Petition for a Rehearing on the issue of risk of institutionalization.

V. Respondent's arguments that Richard should be required by this Court to leave his home and "try" receiving services in congregate settings violate the CMS "Final Rule" that became effective on March 17, 2014.

Respondent argues in the Petition to this Court that Richard is not at risk of institutionalization because he has yet not been required to "try" institutional respite or be admitted to a congregate workshop. The audacity of this argument is more fully revealed when one considers the CMS "Final Rule" which must be applied to all home and community based waiver programs and became effective on March 17, 2014. CMS recognized in this regulation that, just as States drag their feet in implementing the integration mandate contained in *Brown v. Board of Education,* States have been slow to put into practice the requirements set forth in *Olmstead* and the integration mandate of the Americans with Disabilities Act. 347 U.S. 483 (1954).

This Court may take judicial notice of the DHHS website informing the public about this Final Rule which is located at **https://msp.scdhhs.gov/hcbs/.** At this website, HHS informs the public that the Final Rule:

> ...does not just look at location, geography or physical characteristics. It looks at how a person spends their day, where they spend their day and with whom they spend their day. The purpose of the HCBS rule is to enable people to receive services in their home and community, keeping them out of institutions.

Counsel, in DHHS' Petition to this Court, suggests just the opposite for Richard, in gross violation of the Final Rule promulgated by CMS. This Court may also take judicial notice of the DHHS website which, strangely enough, shows that Mr. Hepfer is actually a member of a work group established by DHHS to implement this Final Rule. See https://msp.scdhhs.gov/hcbs/sites/default/files/HCBS%20Rule%20Workgroup%20Member%20

List.pdf. But the proposal Respondent presented to this Court in its Petition for Rehearing for meeting Richard's needs totally ignore this recent mandate to speed up the process of complying with *Olmstead* and the integration mandate.

The Rule was also explained by the Director of DDSN in a powerpoint located at http://ddsn.sc.gov/about/recentnews/Documents/Systems%20In%20Change.pdf and that document is also subject to judicial notice under Rule 201 of the South Carolina Rules of Evidence. A copy of excerpts from that powerpoint presentation to DDSN Commissioners is attached as Exhibit 2, which is also subject to judicial notice under Rule 201. The Final Rule establishes specific guidelines States must meet to assure that they comply with the integration mandate of *Olmstead* and with the Americans with Disabilities Act. This Rule requires DHHS to consider where, how, and with whom Medicaid waiver participants spend their day. Exhibit 2. It requires States to give waiver participants "access to the benefits of community living and the opportunity to receive services in the most integrated setting." It defines a "home and community based setting" as one that "is integrated in and supports access to the greater community.," one which "Provides opportunities to seek employment and work in competitive integrated settings, engage in community live, and control personal resources;" "Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services;" and, importantly "Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting." Exhibit 2. In order to be a "home and community based setting," DHHS must ensure " an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint." DHHS must assure that the placement "Optimizes individual

initiative, autonomy, and independence in making life choices" and "Facilitates individual choice regarding services and supports, and who provides them." Id.

The Final Rule requires the State to assure CMS that waiver participants "have freedom and support to control their schedules and activities and have access to food any time." Most importantly, according to Director Buscemi: "The new rule **switches the burden of proof to each state** to demonstrate that whatever models the state has in place are inclusive versus listing examples that are not." Exhibit 1. (Which is subject to judicial notice under Rule 201). Under this Rule, ICF/MR settinngs are presumed NOT to be home and community based, nor are "Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid home and community based services are presumed NOT to be community based." Exhibit 2.

In short, the new Final Rule requires DHHS and DDSN to provide services in settings where persons like Richard can be fully integrated into the community, rather than being segregated and isolated with other disabled people in workshops or institutions, like Respondent's counsel suggests in the agency's Petition for Rehearing.

Respondent's Petition for Rehearing suggests that Richard attend a DDSN Day Program. But Dr. Buscemi has admitted that **"The Day Program structure that currently exists in the SC DDSN system is given as an example of something that is not community inclusive." Exhibit 2.** DDSN has acknowledged that its Day Programs are not community inclusive because "individuals go to a building to spend their entire day with other people who have a similar diagnosis as themselves," they "do almost the same thing everyday." and "rarely see people that are not paid support staff."

Richard prays that this Court consider and give the "greatest of deference" to the opinions of his qualified medical professionals who have determined, based on their knowledge of his condition and needs, as well as Ms. Mullis' intimate familiarity of the workshop system, that the Court deny Respondent's Petition for Rehearing the issue of his risk of institutionalization. Richard respectfully requests that this Court will be even more convinced now that DHHS has violated the Americans with Disabilities Act and that it will order DHHS to provide the services Richard's physician has ordered, without remand back to the agencies. By the filing of that Petition, and by its refusal to let go of DDSN's relentless attempt to force Richard into its congregate programs, the agency has demonstrated an obstinate refusal to comply with the integration of the Americans with Disabilities Act.

Richard prays that this Court will determine that he is the prevailing party entitled to legal fees and costs, including the cost of having to defend himself against this most recent attempt to tear apart his plan to remain in his own home.

CMS made it clear in this Rule that DHHS must "Demonstrate that individuals lead individual lives." Exhibit 2. That is exactly what Richard wishes to do, just to be provided with the services necessary to remain in his home, with his family and friends in the community, without further threat of being forced into an unsafe day or residential program, where others will set his schedule, determine what he eats and when he eats, and control his access to the community. Respondent has clearly failed to provide any substantial, probative or reliable evidence in support of its argument that Richard is not at risk - even serious risk - of institutionalization and their Petition should be denied, with fees and costs awarded to Richard and DHHS should be ordered to promptly provide the services ordered by Dr. Joseph.

Respectfully submitted,

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

Attorney for Richard Stogsdill

October 2, 2914

Exhibit 1

Meeting Minutes from
SC DHHS "CMS FINAL RULE ON MEDICAID HCBS"
WORGROUP
dated February 26, 2014

Meeting Minutes
CMS Final Rule on Medicaid HCBS

Subject	Initial Meeting	Date/Time	February 26, 2014 /3:30 PM - 5 PM
Location	DHHS Jefferson Square, J11 Conference Room		

Attendees

SC HHS	Y/N	SC HHS	Y/N	Protection & Advocacy	Y/N
Pete Liggett	Y	Brenda Hyleman	N	Gloria Prevost	Y
Kelly Eifert	Y	Alexis Martin	N		
Shealy Reibold	Y				
Rick Hepfer	Y				
George Maky	Y	DDSN	Y/N		
Kara Wagoner-Lewis	Y	Beverly Buscemi	Y		
Anita Atwood	Y	Susan Beck	Y		
Mike Reynolds	Y	Janet Priest	Y		
Jocelin Dawson	Y	Jacob Chorey	Y		
Cindy Pedersen	Y	Tom Waring	Y		
Lisa Ragland	Y	Dave Goodell	Y		
Belinda Adams	Y	DMH	Y/N		
Sherry Everett	Y	Ligia Latiff-Bolet	Y		
AnnMarie Dwyer	Y				
Jennifer Gilmore	N				

Agenda

No.	Topic	Owner	References/Handouts
1.	Introduction	Pete Liggett	
2.	Identification of Issues		
3.	Timelines and Transition Plan		
4.	Scope of Work		
5.	Other		

Key Points Discussed

No.	Topic	Highlights
1.	Introduction	• Pete welcomed group; Discussed intentionality of group to address changes needed due to CMS Final Rule • Views this as an opportunity to make improvements • We should look at others states to see what they are doing • Beverly noted that this does not lessen the impact of Olmstead but dovetails with it as evidenced by the interagency cooperation between CMS and DOJ
2.	Identification of Issues	• Timeline for submission of Transition Plan • Assessment of Residential settings where HCB services provided

		• Assessment of other day facilities where HCB services provided • Populations impacted • Medicaid Policy/service authority • Person-centered planning • Rate structure for services • 1915 (i) service authority • Financial impact • Quality assurance processes/systems • Lease agreements for residential placements (provider owned properties) • Bigger question –how far beyond our waivers do we want to extend our plan/change? o Mentally ill o CRCFs o Other agencies to partner with to affect this change? • SC School for Deaf and Blind • Systematic assessment of level of need for individuals • Service –Home Supports- can we utilize/expand to help meet requirements? • Impacts to systems (like IT for billing, financial reporting, etc)
3.	Other issues/considerations	• Beverly noted that this rule is a philosophical shift in that the burden is placed on the states to prove settings are integrated into the community • Advocacy groups not all in agreement with new requirements of Final Rule • Pete wants to make sure we work with the Provider community to assist with this transition • Pete would like this group to look beyond just waiver populations and requirements; perhaps even beyond the Medicaid population – culture change in SC (ex: Prison population, homeless population, etc)
4.	Others to Invite	• Vocational Rehabilitation • Office on Aging – Lt. Gov. • AARP • Joy Jay/Phil Emery • CRCF Association • Consumer(s) • Provider(s) • Tim Rogers

Meeting Minutes
CMS Final Rule on Medicaid HCBS

		• Shelia Chavis & Office of Communications • SC School of Deaf & Blind
5.	Transition Plan	• There is a master transition plan that the state must submit that addresses how it will come into compliance with the Final Rule for all of its Waivers • The timeframe for submitting that Master plan impacted by submission of Waiver renewals or amendments after the effective date (March 17, 2014) • ID/RD Waiver renewal and PDD Waiver Renewal should happen at end of September • CLTC may also be submitting waiver amendments - related to the Duals Demonstration – at the end of September also • Those renewals or amendments must include a transition plan as it relates to those specific waivers • 120 days later after submission of the renewals/amendments (whichever is first), DHHS must submit the Master Transition Plan for the state (all 1915 Waivers) • Need to review services for all waivers to see what should be addressed to come into compliance? • How do we tackle these tasks?
6.	Scope of work	Divide issues into tasks; create subgroups to address

Action Items

No.	Action Item	Owner	Target Completion Date
1.	Create small group to organize issues/tasks before next meeting	Pete/Kelly	3/7/2014
2.	Invite other stakeholders identified to next meeting	Kelly	3/5/2014

Next Meeting: Monday, March 10th, 9:30 AM – 11 AM, DHHS Jefferson Sq., J10 Conference Rm.

Exhibit 2

SC Department of Disabilities and Special Needs: Systems in Change

March 20, 2014

Presented by Dr. Buscemi at DDSN Commission Work Session

SC Department of Disabilities and Special Needs

Systems in Change

March 20, 2014

Commission Work Session

1008

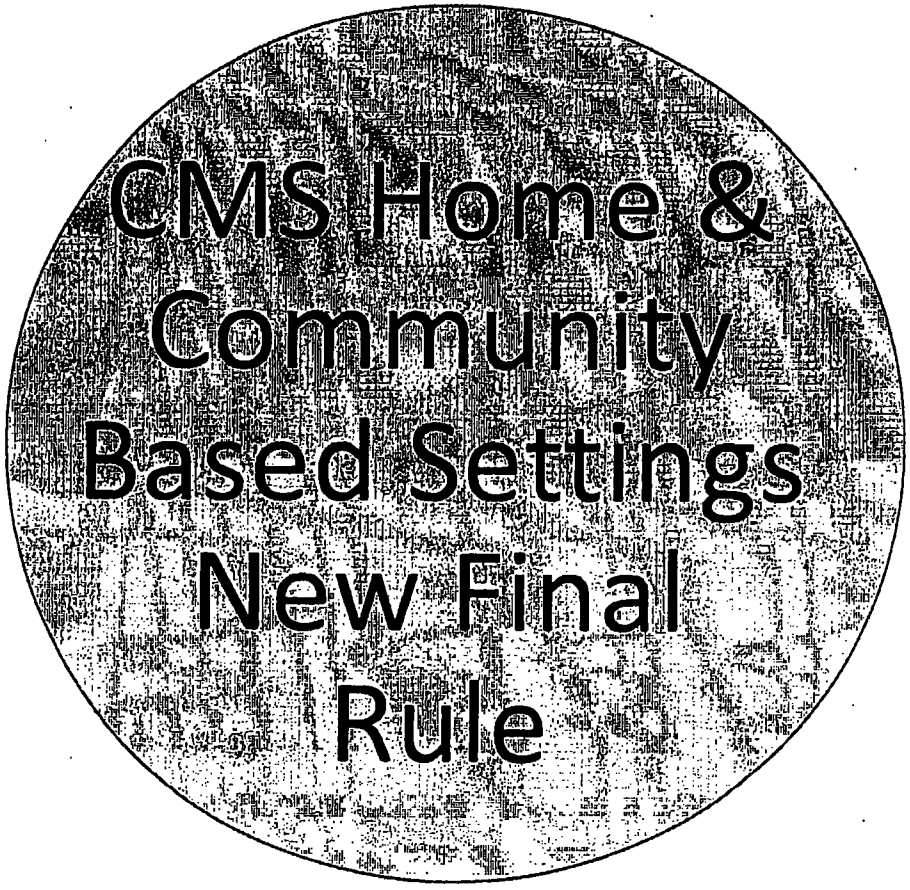
SC Department of Disabilities and Special Needs

- New approaches and requirements by Medicaid at the federal and state level are necessitating significant changes with the SC DDSN system.
- Many of these new approaches and changes require an examination of multiple systems and business processes.

SC Department of Disabilities and Special Needs

- While reviewing all of the elements of change affecting the statewide system, DDSN is committed to keeping the consumers and families first.
- The agency will make every effort to ensure that changes do not negatively affect families and that all essential needs are met.

Changes Impacting DDSN's Statewide System



Center for Medicaid/Medicare Services
Home and Community Based Settings
New Final Rule

Effective March 17, 2014

1011

HCBS NEW FINAL RULE

- New Home and Community-Based Setting (HCBS) Final Rule applies across multiple populations:
  - Intellectually Disabled/Related Disability
  - Autism
  - Mentally Ill
  - Elderly
- The ID/RD and Autism populations are at the heart of the new rule and will likely be the focus of follow up action from CMS and DOJ.

HCBS NEW FINAL RULE - CONTINUED

- Changes the definition of community inclusion for all Medicaid waiver services
- Previously the rule focused on residential settings, where the person lived. Are they integrated into the community?
- The new rule looks at not only where a person lives, but where, how, and with whom they spend their day.

HCBS NEW FINAL RULE - CONTINUED

- The new rule requirements establish an outcome oriented definition that focuses on the nature and quality of individuals' experiences .

- The requirements maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting .

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- The new final rule establishes:
  - Mandatory requirements for the qualities of home and community-based settings
  - Settings that are not home and community-based
  - Settings presumed not to be home and community-based
  - State compliance and transition requirements

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- The home and community-based setting:
  - Is integrated in and supports access to the greater community
  - Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
  - Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- The home and community-based setting (continued):
  - Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
  - Person-centered service plans document the options based on the individual's needs, preferences, and for residential settings, the individual's resources

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- The home and community-based setting (continued):
  - Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
  - Optimizes individual initiative, autonomy, and independence in making life choices
  - Facilitates individual choice regarding services and supports, and who provides them

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- Additional requirements:
  - Specific unit/dwelling is owned, rented, or occupied under legally enforceable agreement
  - Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- Additional requirements (continued):
  - If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law
  - Each individual has privacy in their sleeping or living unit

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- Additional requirements (continued):
  - Units have lockable entrance doors with the individual and appropriate staff having keys to doors as needed
  - Individuals sharing units have a choice of roommates

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- Additional requirements (continued):
  - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
  - Individuals have freedom and support to control their schedules and activities and have access to food any time
  - Individuals may have visitors at any time
  - Setting is physically accessible to the individual

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- The new rule switches the burden of proof to each state to demonstrate that whatever models the state has in place are inclusive versus listing examples that are not.
- This provides a lot of flexibility to states to develop various models that take into account specific local community dynamics.
- But that flexibility makes it difficult to know for certain in advance exactly what will be approved and what will not.

HCBS NEW FINAL RULE - CONTINUED

- Settings presumed NOT TO BE home and community based:
  - Institution for mental diseases (IMD)
  - Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
  - Nursing facility
  - Hospital

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- Settings presumed NOT TO BE home and community based (continued):
  - Settings in a publicly or privately-owned facility providing inpatient treatment
  - Settings on grounds of, or adjacent to, a public institution
  - Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- South Carolina Residential Settings
  - Some settings that may not meet the new rule:
    - Clusters of homes in close proximity
    - Homes located on the same campus or directly beside a day program or other large facility
    - Supported apartment settings where the apartments are clustered together and not interspersed within a larger complex of apartments.

HCBS NEW FINAL RULE - CONTINUED

- The Day Program structure that currently exists in the SC DDSN system is given as an example of something that is not community inclusive.

HCBS NEW FINAL RULE - CONTINUED

- What makes the current day program structure not community inclusive?
  - The fact that individuals go to a building to spend their entire day with other people who have a similar diagnosis as themselves.
  - People do almost the same thing everyday.
  - Individuals rarely see people that are not paid support staff

HCBS NEW FINAL RULE - CONTINUED

- What does CMS want the states to do?
  - Demonstrate that individuals lead individual lives
  - Individualize programming options
  - Increase employment opportunities

HCBS NEW FINAL RULE - CONTINUED

- What is the timeframe for implementation of the new final rule?
  - States have to submit a plan of compliance in no more than one year from March 17, 2014.
  - If a state submits a waiver renewal or amendment, the submission must include a plan for that waiver population, and a plan for the entire state must be submitted within 120 days.

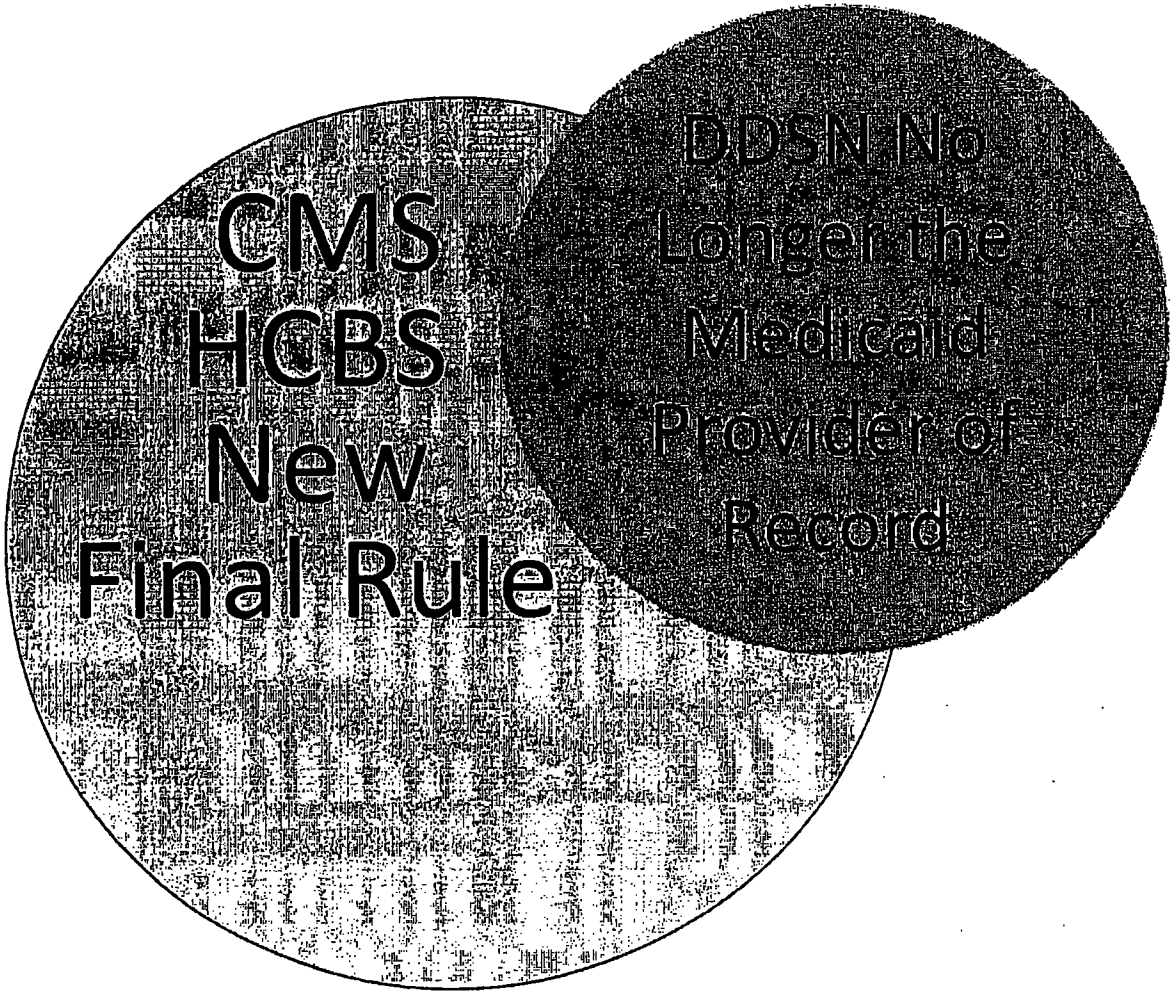
HCBS NEW FINAL RULE - CONTINUED

- What is the timeframe for implementating the new final rule?
  - SC must submit a waiver renewal for the ID/RD and PDD waivers by end of September 2014.
  - Therefore, the plan for the entire state must be submitted before the end of December 2014.

HCBS NEW FINAL RULE - CONTINUED

- What is the timeframe for the new final rule?
  - CMS will allow states five years from submission of the plan to come into compliance for all populations.

Changes Impacting DDSN's Statewide System



SC DDSN No Longer the Provider of Record for all Medicaid Services

- For almost 30 years, SC DDSN has been the provider of record for all Medicaid services for the populations served by the agency.
- This system of an Organized Health Care Delivery System has been accepted in the past by CMS with the support of SC DHHS (Medicaid agency).

SC DDSN No Longer the Provider of Record for all Medicaid Services - continued

- The current Administration of SC's Medicaid agency does not support this organizational structure.
- Therefore, DDSN must now change how the agency's statewide delivery system is organized.

SC DDSN No Longer the Provider of Record for all Medicaid Services - continued

- DDSN's role will change.
- DDSN will continue to be the subject matter expert for DDSN's populations.
- DDSN will continue to operate the four waivers on behalf of DHHS.

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

- DDSN will continue to develop policy.
- DDSN will continue to monitor services.
- DDSN will continue to assure health and safety.
- DDSN will continue quality assurance role.

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

- The fact that DDSN will no longer be the provider of record requires the agency to re-examine all business processes.

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

- Each function must be examined to determine which of three areas it falls into:
  1. Service
  2. Administrative
  3. Not Billable to Medicaid

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

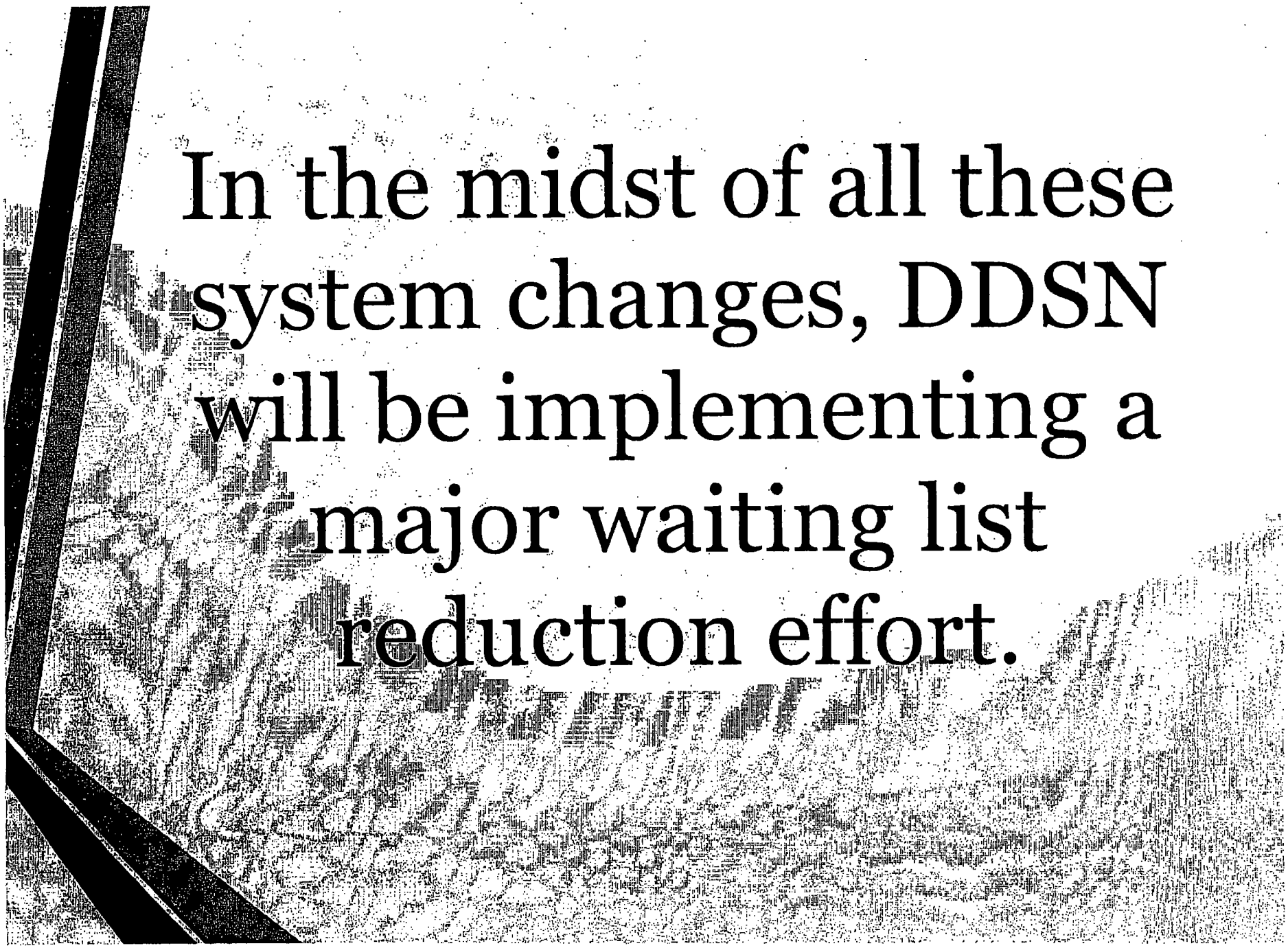
1. Service
   - Billable to Medicaid at the service rate
   - 30 % state dollars and 70% federal dollars
   - DDSN has previously been able to bill all Medicaid services at the service rate because we were the provider of record.
   - DDSN will likely be able to only bill for some service functions in the future, such as ICF/IID.

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

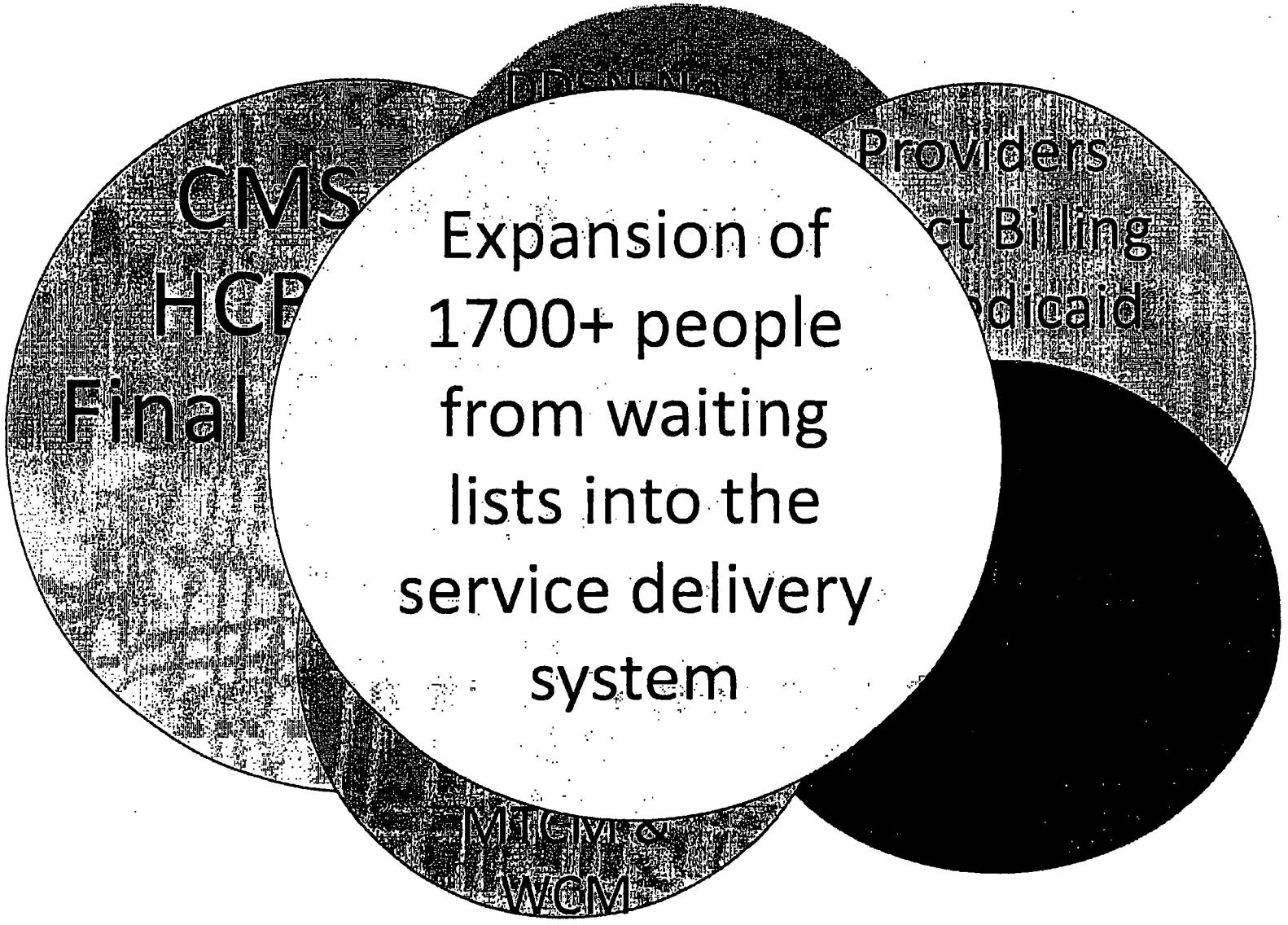
2. Administrative
   - DDSN will enter into new administrative contracts with DHHS.
   - Administrative contracts are for the purpose of assisting with the administration of the Medicaid program.
   - Only those functions that assist with the administration of the Medicaid program can be included in an administrative contract.

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

2. Administrative - continued
   - Billable to Medicaid at an administrative rate
   - 50 % state dollars and 50 % federal dollars
   - This is a reduction in federal dollars
   - It will cost 20 % more state dollars to perform the same functions previously billed at the service rate.


In the midst of all these system changes, DDSN will be implementing a major waiting list reduction effort.

Changes Impacting DDSN's Statewide System



Expansion of Services to Waiting List

- Head and Spinal Cord Injury (HASCI) Program
  - Currently expanding HASCI services to approximately 300 additional people currently on the waiting list.
  - This represents almost a 50 % increase in the total number of people served through this program.
  - Will include primarily in home supports, but may include limited residential expansion.

Expansion of Services to Waiting List – continued

- Intellectual Disability/Related Disability (ID/RD) and Community Supports (CS) Waivers
  - Starting July 2014 expanding ID/RD and CS services to approximately 1400 additional people.
  - This represents over a significant increase in the total number of people served through these programs.
  - Will include primarily in-home supports, and limited residential expansion as well.

Expansion of Services to Waiting List – continued

- THIS IS GREAT!
  - The appropriation of additional funds to move the waiting list represents a dedicated commitment on behalf of the Governor and General Assembly to people with disabilities.
  - This will offer significant relief to families who are in need of and waiting for services.

Expansion of Services to Waiting List – continued

- THIS IS GREAT, but carries some challenges.
  - It will require a significant staff effort to roll out such a high number of waiting list slots to new people in such a short period of time.
  - In order for all the necessary Medicaid enrollment activities to be completed, slots are allocated in manageable "batches."

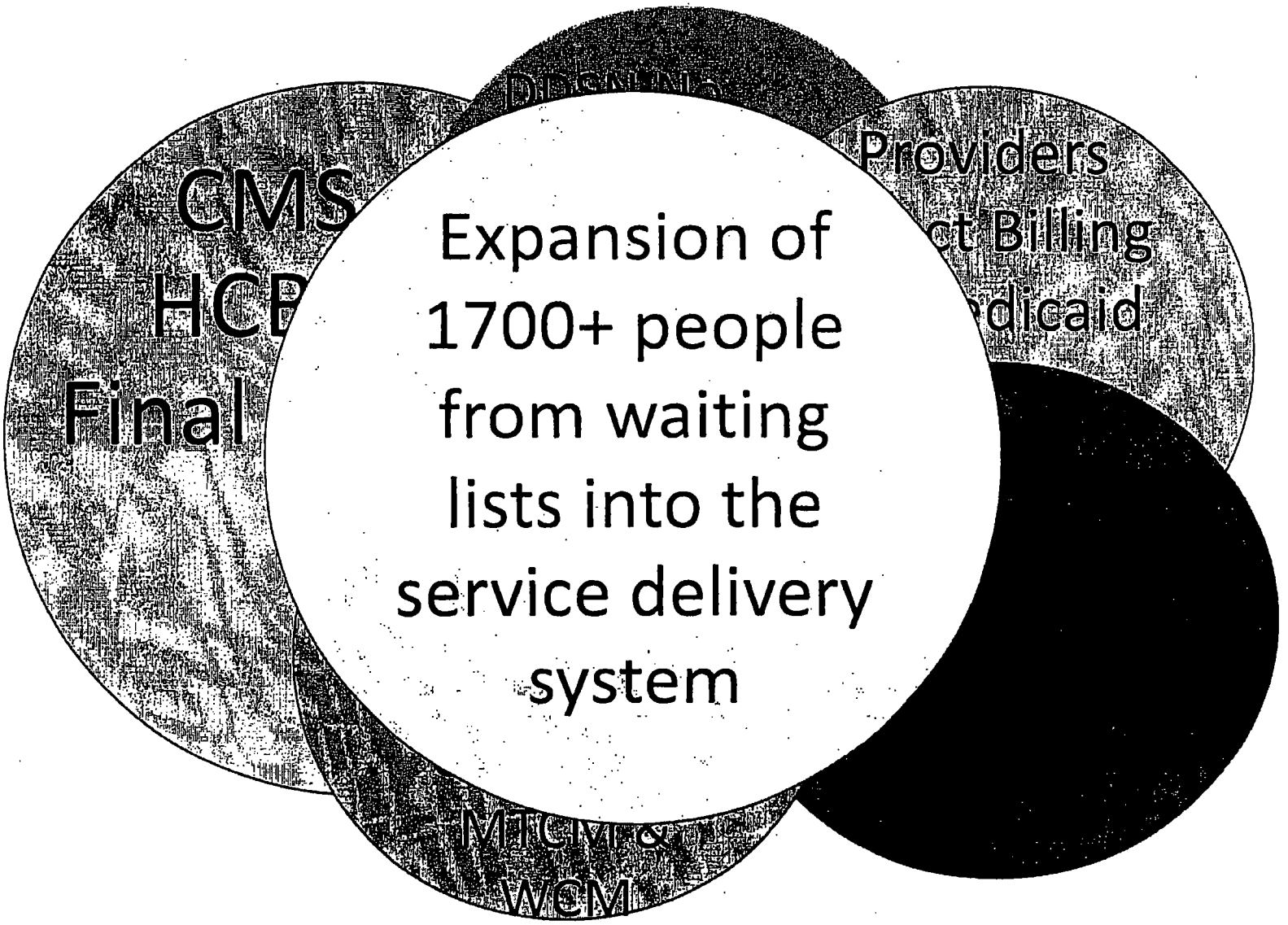
Expansion of Services to Waiting List – continued

- Some areas of the state still have capacity that can accommodate expansion to serve additional people.
- In other areas of the state where providers are at or near capacity, expansion needs to occur in such a way that it is consistent with the new Home and Community Based Settings Final Rule from CMS.

Expansion of Services to Waiting List – continued

- Should not develop more traditional work shop settings
- Need to look at targeted expansion that is consistent with community inclusion
- Expand employment opportunities

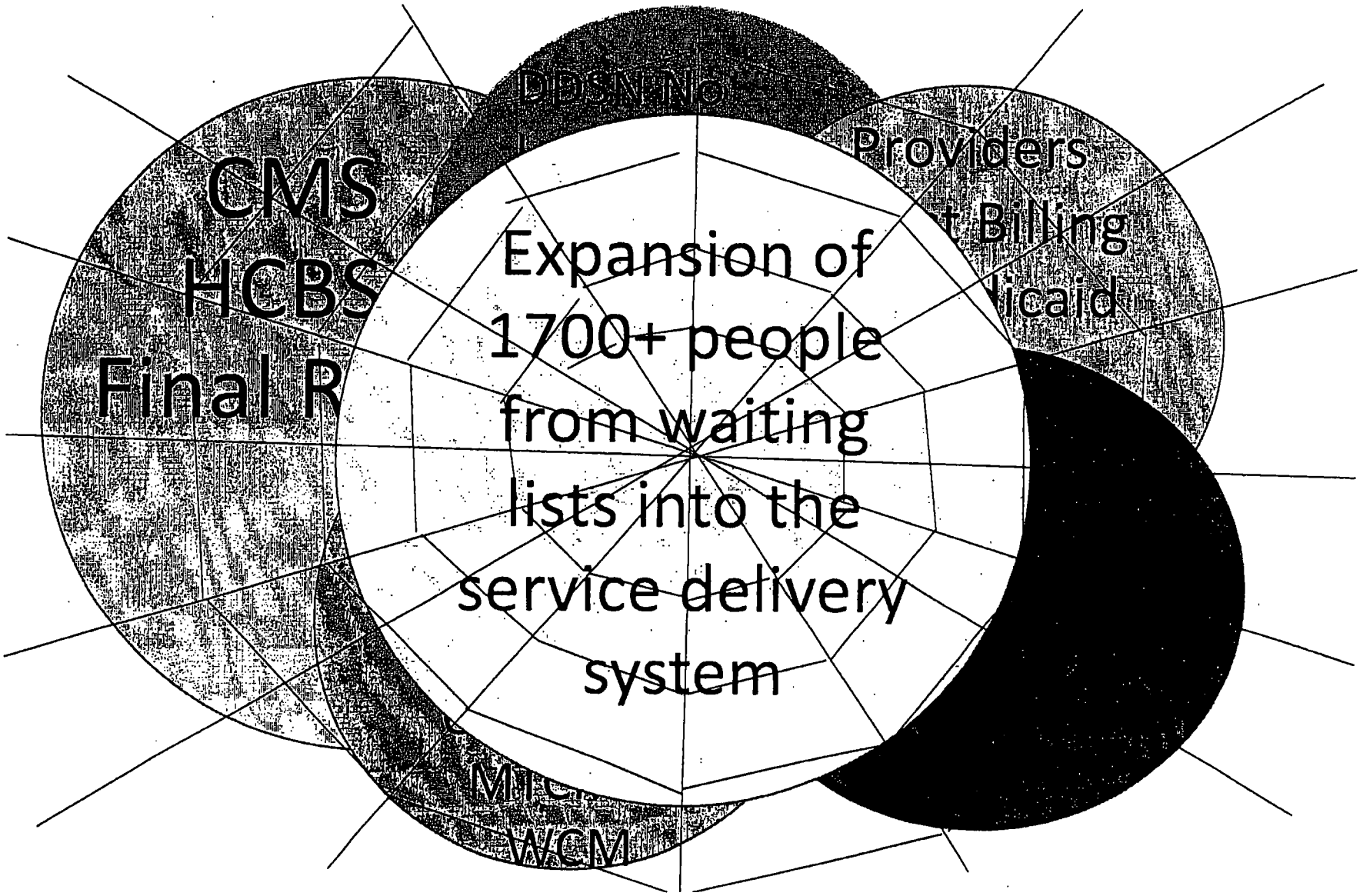
Changes Impacting DDSN's Statewide System



- Each of these circles of change requires examinations and possible modifications of DDSN's business processes.

- Think of a spider web overlapping all of these circles of change.

Changes Impacting DDSN's Statewide System



1053

- Each line of the spider web represents an individual DDSN business process.
- If you pull one of the lines of the web, it affects all of the other lines.
- Changing one business process often necessitates changing multiple processes that are affected by that one change.

Focusing on our Mission

- DDSN will continue to focus on what is most important: meeting the needs of the people we support.
- DDSN will continue to focus on individualized supports and services and increased community participation.
- DDSN is committed to working with self-advocates, families, providers, and other stakeholders to improve services though these system changes.

STATE OF SOUTH CAROLINA

In the Court of Appeals

RECEIVED

OCT 0 2 2014

SC Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Carolyn C. Matthews, Administrative Law Judge

Case No. 10-ALJ-08-0774-AP

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent

---

RETURN TO APPELLANT'S PETITION FOR REHEARING

In response to the Appellant's Petition for a Rehearing on various issues, the Respondent offers the following Return on a few points:

1. Deference to the Appellant's attending physician (Appellant's Issue 2): A close reading of Justice Kennedy's concurrence in the Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999), at 609 & 610, reveals that nothing is said regarding the treating physician's discretion about what services should be offered. The concurrence deals with two (2) decisions to which deference is due:

a. The treating physician's decision about whether to deinstitutionalize patients "...into settings with too little assistance and supervision...;" and

b. "...the program funding decisions of the state policymakers."

Thus, the treating physician's recommendations with respect to setting must be tempered by the State's discretion for program funding. Olmstead does not stand for the proposition that the State must give uncritical discretion to the treating physician's recommendation as to the level of services provided, nor that the treating physician's recommendations as to level of services is dispositive.

2. Failure to comply with the Administrative Procedures Act (Appellant's Issue 4): As the court correctly found, in Doe v. South Carolina Department of Health and Human Services, 398 S.C. 62 (2011), the South Carolina Supreme Court determined that South Carolina could have listed additional criteria in the waiver application..." Furthermore, as an additional ground, the Department's promulgated regulations, at S.C. Code Ann. R. 126-300(D), 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.

3. Violation of due process (Appellant's issue 5): In this case, the original hearing Officer for the agency determined that the agency did not afford proper notice to the Appellant of the changes in the Waiver that affected him. The agency acknowledges that error and the flaw in the process. However, the fact that the Appellant, through counsel, sought a reconsideration of the limits two (2) days before they became

effective indicates that Appellant did have actual knowledge of the effects that the limits would have on his services. Furthermore, the Reconsideration decision and notice of appeal rights issued by Dr. Buscemi (R. pp. 940 & 941) provided adequate notice of the issues and the opportunity to be heard by the DHHS Appeals Division. Therefore, no substantial prejudice can be shown as required by Jones v. S.C. Dep't of Health and Environmental Control, 384 S.C. 295 (Ct. App. 2009)

4. Violations of the "reasonable promptness" provision (Appellant's Issue 6): 42 USC §1396a(a)(8) provides as follows:

> A State plan for medical assistance must—
> (8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals; (Emphasis added)

The rule applies to the reasonably prompt provision of what the Program staff authorizes and determines is appropriate. Obviously, the applicant can dispute, through an administrative appeal, the scope of the authorization, but the applicant does not automatically get anything he or she additionally requests while the appeal is pending. In any case, any misunderstandings are not relevant here because the Hearing Officer had substantial evidence to find that authorized services themselves had been provided with reasonable promptness. It is the amount of the services that is at issue here.

5. Violation of the "comparability" requirements (appellant's Issue 7): The regulation (§440.240) clearly requires comparability within the State Plan, the contract with the federal government that describes the State's Medicaid Program. The implementing federal regulations in 42 CFR provide:

§ 440.240 Comparability of services for groups. Except as limited in §440.250— (a) The plan must provide that the services available to any categorically needy beneficiary under the plan are not less in amount, duration, and scope than those services available to a medically needy beneficiary; and (b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all beneficiaries within the group: (1) The categorically needy. (2) A covered medically needy group.

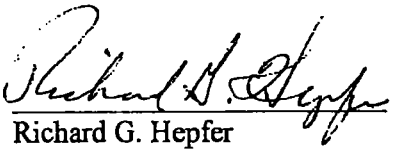
This provision clearly deals with the requirement that services be the same as among various eligibility groups within the categorically needy (low income, aged, disable, etc.) and groups within the medically needy (such as those who can spend down their resources to become eligible) and between the two (2) categories. The medically needy are not covered in South Carolina. The regulation addresses services provided under the State Plan. Waiver services are not addressed by the regulation. In fact, the designation "waiver" indicates that certain requirements of the Medicaid program, such as comparability are "waived" so that services can be provided to the waiver participants in ways not allowed under the regular Medicaid Program – in this case in ways not comparable to the way services are provided to categorically eligible recipients under the State Plan.

The Waiver document at issue here, at item 4-A specifically requests waiver of the comparability requirement so that the waiver services may be offered to the individuals eligible for the waiver and not to individuals who qualify under the groups specified in the State Plan. Therefore the comparability provisions do not apply. The waiver document is at

https://www.scdhhs.gov/sites/default/files/SC.0237.R04.04%20ID%20RD%20AME

NDED%20CMS%20APPROVAL%202014.pdf.

For the reason specified above, the court should decline to rehear the issues set forth by the Appellant in his Petition for Rehearing.



Richard G. Hepfer
Of Counsel
South Carolina Department of Health
and Human Services
1801 Main Street
P.O. Box 8206
Columbia, South Carolina 29202-8206
Voice: (803) 898-2791
Fax: (803) 255-8210
Bar #3076
Attorney for the Respondent

RECEIVED
SEP 25 2014
SC Court of Appeals
73468

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

Case No. 2013-000762

Richard Stogsdill ..... Appellant,

v

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

APPELLANT'S PETITION REQUESTING REHEARING

Patricia L. Harrison
611 Holly Street
Columbia, South Carolina 29205
(803) 256-2017
Attorney for Appellant

Richard G. Hepfer, Esq.
Office of General counsel
South Carolina Department of Health and Human Services
PO box 8206
Columbia, South Carolina 29202-8206
Attorney for Respondent

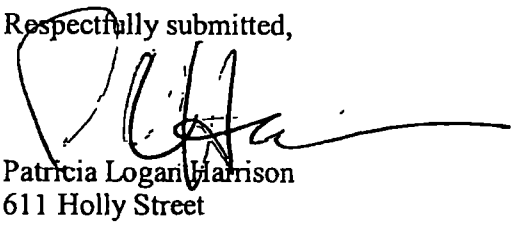
In order to preserve Appellant Richard Stogsdill's right to appeal, Appellant files this protective Petition, and the attached Memorandum, pursuant to Rule 221(a) of the South Carolina Appellate Court Rules. Richard Petitions this Court for a Rehearing of its decision issued on September 10, 2014. For the reasons set forth in the attached Memorandum, Richard respectfully requests that this Court reconsider its decision as it relates to the following issues to the extent they were not favorably ruled upon in Richard's favor in that Opinion:

Issue 2	The mandate of the United States Supreme Court requires DHHS to give the "greatest of deference" to his physician's orders and they have violated that Court's Order, as established in *Olmstead v. L.C.* (Appellant's Brief at 18 - hereinafter referred to as "AB at 18")
Issue 4	DHHS has failed to comply with the South Carolina Administrative Procedures Act (SC APA) and the "reasonable standards" requirement of the Medicaid Act (AB at 35)
Issue 5	Richard's Due Process rights (including the right to notice) and the Separation of Powers requirement of the South Carolina Constitution have been violated by DHHS (AB at 41)
Issue 6	DHHS has violated the "reasonable promptness" requirement of the Medicaid Act contained at 42 U.S.C. 1396a(a)(8) (AB at 47)
Issue 7	DHHS has violated the "comparability" requirements of the Medicaid Act at 42 U.S.C. 1396a(a)(10)(B) (AB at 48)

This Motion is protective, because the issues Richard asks this Court to reconsider are currently pending in a parallel case in the federal district court in *Richard Stogsdill et. al. v. Sebelius* and that case is scheduled to be tried in November, 2014 (or at least to pick the jury by that date). Case No. 3:12-cv-007-JFA. The parties have fully briefed that case in the federal district court and have filed motions for summary judgment, which have not yet been ruled upon by that court.

Appellant respectfully files this protective Petition for a rehearing.

Respectfully submitted,



Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
plh.cola@att.net
S.C. Bar No. 0011309

Attorney for Richard Stogsdill

September 25, 2014

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

RECEIVED
SEP 25 2014
SC Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

Case No. 2013-000762

Richard Stogsdill ..... Appellant,

v

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

APPELLANT'S MEMORANDUM IN SUPPORT OF PETITION REQUESTING REHEARING

Patricia L. Harrison
611 Holly Street
Columbia, South Carolina 29205
(803) 256-2017
Attorney for Appellant

Richard G. Hepfer, Esq.
Office of General counsel
South Carolina Department of Health and Human Services
PO box 8206
Columbia, South Carolina 29202-8206
Attorney for Respondent

Introduction

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

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

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

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

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

---

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

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

- Richard's treating physician determined that he required 2 caregivers for 8 hours a day (total 16 hours a day).
- Richard continued to need the number of respite hours he was receiving in 2009.[3]
- Richard's needs for socialization were not being met.

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

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

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

---

[3] Richard's father died in 2013, leaving his mother as the sole breadwinner and family caregiver and his respite hours were increased to 240 hours a month. But he requires two persons to safely lift him, when he moves to or from his bed to or from his wheelchair and mid-day when he is toileted. R. 241, 306, 309 and 326.

reductions.[4] On remand to DHHS, some time after November 16, 2009, DDSN determined that

[4] Rule 201 of the South Carolina Rules of Evidence require this Court to take judicial notice of facts that are not "subject to reasonable dispute" because they "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Rule 201(b). That Rule provides that the court must take judicial notice "if a party requests it and the court is supplied with the necessary information." The websites of the South Carolina Comptroller General and the Governor of South Carolina are sources whose accuracy should not be questioned. The Comptroller documented that in FY 2010 DHHS allowed $225,945,013 of funds allocated by the General Assembly to "lapse." *See* page 4 at http://www.cg.sc.gov/publicationsandreports/Documents/Press/2010YearEndPressRelease.pdf. Had these funds been used, as intended by Congress in the American Recovery and Reinvestment Act (ARRA, P.L. 111-5), to maintain and expand Medicaid services, they could have provided $1,129,725,000 of Medicaid services, during FY 2010 alone (with the 4 to 1 federal match in effect during the years the ARRA funds were paid to DHHS, from 2009 to 2011). This Court may also take judicial notice of the fact that during the most recent fiscal year, DHHS failed to spend $280 million of funds that were allocated by the General Assembly, nearly 25% of its state budget. *See* http://www.cg.sc.gov/publicationsandreports/Documents/Press/2014YearEndPressRelease.pdf at page 4. These unexpended funds could have produced more than $800 million in income, had they been matched with federal dollars, at the current 70% match rate, to provide health care services to South Carolinians like Richard. Respondent's claims of lack of funding ring hollow and leave real live people like Richard and his mother on the edge of their worst nightmares coming true. *See Unequal Justice for South Carolinians with Disabilities* letter and report at R.

Richard needed an additional 15 hours a week of Adult Companion Services. Exhibit 2. Affidaivt of Nancy Stogsdill dated September 25, 2014. But no written decision was issued and no notice of appeal of the number of hours approved was provided to Richard or his counsel. No one made any attempt to comply with the hearing officer's order requiring that input be solicited from Richard's treating physician, Dr. Joseph, in preparing his plan of care.

Instead, less than one month later, in December, 2009 DDSN sent out an announcement to Medicaid waiver participants that a 28 hour cap was being imposed on Personal Care Attendant and Adult Companion Services, caps were being imposed on Respite services and Physical Therapy, Occupational Therapy and Speech and Language Services were being terminated as waiver services. It is uncontested that this announcement did not meet the notice

---

484 and 486. The truth matters. And the truth is that neither DHHS nor DDSN have suffered from the lack of funding since Richard's 2009 appeal was filed. The month that DHHS submitted the waiver application to CMS in 2009, claiming to have to reduce services due to lack of funding, DDSN was sitting on a $7.845 million "excess funds" account. R. 882-884. Even though DDSN transferred $5.944 million of these funds, for purposes not approved by the General Assembly, while its members were adjourned. R. 879. Even so, by the end of FY 2014, according to the Governor's Executive Budget for FY 2015, DDSN had accumulated more than $9 million in excess funds by the end of FY 2014. These funds are believed to be held in an account not subject to oversight by the General Assembly. (According to DDSN Commission minutes from January, 2014, legal counsel at the Budget and Control Board advised DDSN to hold these "excess" funds to cover "a pending lawsuit." *See* http://www.ddsn.sc.gov/DDSNCommission/Documents/meeting%20minutes/01%20January%2016,%202014%20Commission%20Mtg%20Minutes.pdf.) Over and above these "excess funds," the General Assembly approved state funding of $14.8 million in new permanent funding to be paid to DDSN for FY 2015. *See* http://ddsn.sc.gov/DDSNCommission/Documents/meeting%20minutes/06%20%20June%2019,%202014%20Commission%20Meeting%20Minutes.pdf. This could produce more than $45 million in additional funding for the agency during FY 2015 alone, if these funds are spent, as intended, to provide Medicaid waiver services to disabled persons like Richard. Yet, DHHS continues to work to defeat Richard's battle to remain in the community with its latest Memorandum.

requirements of 42 C.F.R. 431.210.[5] In addition, instead of allocating hours annually, under the "new" waiver, hours were to be allocated either weekly or monthly, prohibiting the "saving" of hours that might be needed in the event of a lengthy illness or other absence of the family caregiver. In that event, under the amended waiver, Richard's only option would be to succumb to his mother's greatest fear in life - the fear she could not even bring herself to speak out loud about - her son being admitted to a DDSN ICF/MR (nursing facility for persons who have mental retardation or a related disability). The number of days allowable in this institutional setting was not capped, and under the "new" waiver, Richard can receive an unlimited number of days in an ICF/MR - the most expensive - and dangerous - setting in DDSN's system. R. 324, 484, 486,

According to the DDSN Commission minutes of May 21, 2009, these reductions were necessary "Due to budget cuts." R. 833. The State Medical Care Advisory Committee, which must review changes to the Medicaid waiver program, was informed by DDSN and DHHS staff

---

[5] The Order of DHHS Hearing Officer Bryson states that:

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

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

that these caps and termination of services was necessitated "Due to the state's budget situation..." R. 844. These reductions and changes were made after the General Assembly adjourned for the year, and they were put into place before that legislative body returned to the State House. The decision to place caps on critical services was made by a few state employees, without even the local DSN Boards knowing the scheme that was afoot that would force waiver participants like Richard out of their homes and into DDSN congregate day and residential settings. R. 914.

Richard joined eight other DDSN Medicaid waiver participants in filing a Petition with the South Carolina Supreme Court in December, 2009, asking that Court to hear their Complaint in its original jurisdiction to prohibit DHHS from enacting these reductions and changes because they were based on false claims of lack of funding that did not exist.[6] R. 337. But that Petition

---

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

was denied and the caps and reductions for persons who had not filed an appeal were scheduled to be put into place beginning on January 1, 2010.

Richard filed a second request for a fair hearing on December 30, 2009, when he learned of the agency's intention to reduce all waiver participants' services. R. 943. It was necessary for him to file this state administrative appeal, to avoid his services being reduced, under the terms of the "new" waiver.[7] On January 11, 2010, DDSN sent Richard Notices of Termination of Services informing him that his Personal Care Services and Respite Services were being terminated. R. 925-926. The reason given for this action was that he "moved out of state." Id. But, Richard has lived in the same house for over ten years. R. 315-316. These are the only notices in the Record.[8] According to Mrs. Stogsdill, a notice of termination of services was also sent to "all of his suppliers," but not to Richard, after he filed his administrative appeal in

---

[7] For the first time, in *Peter B. v. Sanford,* the federal district court issued a preliminary injunction preventing DHHS from reducing the services of DDSN waiver participants. The reductions in services of Michelle M. and Chip E., were scheduled to go into effect on January 1, 2010, but they filed an administrative appeal and a lawsuit in federal court. R&R of then Magistrate Judge Bruce Howe Hendricks dated November 24, 2011. 6:10-cv-00767 adopted *in toto* by order of Judge Michelle Childs on March 7, 2013. The caps were also not imposed in the case of B.H., but the threat was removed only after she filed a lawsuit in the federal court. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0656-AP (S.C.A.L.C. July 19, 2011) and *Hickey v. Forkner*, Case No. 4:10-cv-2696 (S.C.D.C. May 5, 2011). B.W. did not file a federal lawsuit and DDSN reduced her services while her administrative appeal was pending, even though she was under age 21 and was entitled to all medically necessary services under the EPSDT mandate of the Medicaid Act. An emergency appeal was filed weeks ago in the Administrative Law Court, which still has not been ruled upon, and she still is receiving fewer hours than she was receiving when she filed her administrative appeal. *B.W. v. DHHS*, Exhibits 4, 5 and 6.

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

December 2009. Id.

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

But the honest truth was that the cost of the MR/RD Medicaid program actually increased by tens of millions of dollars in 2010, after these caps were imposed and PT, OT and Speech services were terminated from the waiver program. According to the MR/RD Medicaid Waiver filed with CMS by DHHS in 2004, the total cost of the program for 2009 was projected to be $217,252,605, with an average cost per participant of $36,209. R. 236 and 891. Then, CMS sent a letter to DHHS, on November 9, 2009, approving the agency's request of $278,661,600 to operate the program. Under the amended waiver program, the average annual cost per participant was $51,869, according to this application. R. at 75. A few months later, DHHS submitted a new application to CMS dated April 28, 2010, again reporting that the cost of the MR/RD Medicaid program during 2010 to be $278,662,353.40, but this time DHHS reported that the average cost per participant would be $44,232 (which was still an annual increase of $8,023 per participant over the per capita cost in 2009.)

A hearing was held on May 11, 2010 on the appeal Richard filed December 30, 2009. R. 16. The "reasons" provided for the reduction of Richard's services had been (1) drastic budget reductions in funding, and (2) Richard moved out of state. But neither of the "reasons" provided in the "notices" were argued by DHHS at the hearing. The "notices" did not inform Richard that

the issue at the "fair hearing" would be the medical necessity for his services that had been ordered by Dr. Thomas. At the hearing, DHHS presented only two witnesses. Neither of these witnesses had any medical training, they had never met Richard, and neither had reviewed any of his medical records or contacted his physician, as ordered by Hearing Officer Loomis.

At the hearing, Respondent presented Jacob Chorey and Dawn Shealy as their only witnesses. R. 275 to 303. Ms. Shealy held a Bachelor of Arts Degree in Sociology, but she had no medical training. R. 278-279 and 287. In her job, she did not perform any review of medical necessity of services. R. 280 and 281. She had never met Richard and she had no idea whether he could get out of bed, take a shower or feed himself. R. 282. She had not reviewed any medical records or communicated with his physician. Id. She determined that more respite hours were not needed, because his mother only worked "part time" and "we just felt that 40 hours a week of respite was sufficient." R. 284. She never inquired of anyone how many hours Richard's mother worked a week. R. 285. According to Ms. Shealy:

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

R. 288.

Respondent's second witness, Jacob Chorey, held a Bachelor's of Science in Psychology and a Master's of Arts in Counseling, but he had no medical training either. R. 291. He held the position of MR/RD Waiver Program Coordinator at DDSN. Id. Chorey began working for DDSN in September 2009, after DHHS submitted the waiver amendments, but he did not know why the caps were implemented. R. 294-295 and 302. According to Mr. Chorey, his role at DDSN was

"to testify in these types of fair hearings to represent the Agency so even if I don't have a direct role in the determination, I still would have a role in testifying to the processes that have been developed and any related information that I'm aware of." R. 301. He had no personal knowledge of the funding issues associated with the waiver amendments or the events that led up to the decision to cap and terminate services.

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

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

Without objection from Respondent's counsel, Mrs. Stogsdill presented the affidavit of Lennie Mullis, who provides psychological services to Richard, and she described the services provided by Ms. Mullis. R. 312-313. (Affidavit at R. 917). Richard's mother described the

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

Richard's mother testified that Richard's treating physician, Dr. Joseph, had provided medical care to him for 22 years. R. 318. According to Mrs. Stogsdill, Dr. Joseph had watched Richard progress over the years, then he watched Richard "regress" due to "boredom and frustration" when the therapies he received at school were terminated. R. 319-319. She presented the sworn affidavit Dr. Joseph had signed, without objection from DHHS' counsel. R. at 920.

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

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

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

R. 322. If that happened, Richard's mother testified that he "would object violently. And I mean he would - he wouldn't understand why we were doing it. He - I mean he would think that, what happened, you know, what did I do? Why am I being punished? R. 325.

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

At this point in the proceedings, Richard suggests that these issues should be heard, to the extent that they were not favorably addressed in this Court's Order of September 10, 2010, by the federal district court. These issues have been fully briefed by the parties, discovery has been taken and a date for selection of the jury has been set. Alternatively, if this Court determines that it wishes to address these issues, without suggesting that Richard cannot pursue parallel claims in the federal court, he submits the arguments made in his Motion for Summary Judgement filed in the district court for this Court's review and consideration. Exhibit 7.

Grounds for Motion for Rehearing on Issue 4

Grounds for reconsideration of Issue 4 contained in Appellant's Brief at 35, are that the Court appears to have overlooked cases which clarify the limited scope of the *per curiam* opinion

issued by the North Carolina Supreme Court in *Arrowood v. North Carolina Dept. of Health and Human Services* (353 N.C. 351, 543 S.E.2d 481 (N.C. 2001) (hereinafter referred to as *Arrowood II*) in ruling that DHHS does not have to comply with the rulemaking requirements of the South Carolina Administrative Procedures Act. Unfortunately, the arguments made by Respondent in its Memorandum, requesting rehearing, make it clear that relief will not be provided through a remand to DDSN unless Respondent is ordered to comply with the APA to end the arbitrary and capricious manner and methods used by DDSN and DHHS to determine medical necessity for Medicaid services. So it is critical that this Court require Respondent to establish reasonable standards for the operation of the ID/RD Medicaid Waiver program through the rulemaking procedures mandated by the General Assembly in the SC APA. It is also only fair and just that until such standards are established that he be provided the services ordered by his physician. The medical need for those services has been established twice now in "fair hearing" where DHHS failed to provide evidence from any qualified medical source (or any medical source, qualified or not) to contradict the well supported treatment orders of Richard's treating physician.

In *Doe v. Kidd II,* the United States Court of Appeals for the Fourth Circuit ruled that federal district courts "in the context of the Medicaid Act" are "invested with broad equitable powers to style any appropriate remedial relief." Citing *Alexander v. Hill*, 707 F.2d 780, 783 (4th Cir. 1983) (permitting a district court to exercise its broad equitable powers in fashioning a remedy to address the continuing failure of a state to comply with Medicaid regulations). The Fourth Circuit noted in *Doe II* that in *Smith v. Miller*, the Seventh Circuit concluded that "no provision of the Medicaid Act or the Constitution restricts the authority of the courts to award equitable relief." 665 F.2d 172, 175 (7th Cir. 1981). Section 1-23-630(A) of the South Carolina

Administrative Procedures Act provides that an administrative law judge "has the same power at chambers or in open hearing as do circuit court judges and to issue those remedial writs as are necessary to give effect to its jurisdiction." S.C.Code Ann. § 1-23-630(A) (2005). Article V. of the Constitution of the State of South Carolina provides at § 20 that:

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

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

benefits would be limited and he agreed to a termination date for those benefits. Id. Subsequently, unlike the present case, the North Carolina General Assembly enacted a statute limiting those benefits to 24 months. Id. Despite the plaintiff having agreed in writing to the 24 month limitation, the North Carolina Court of Appeals ruled in *Arrowood I* that the limitation was unenforceable, because it had not been promulgated as a regulation under the NC APA at the time the plaintiff's benefit period began.

It is interesting to note that on the same day that the North Carolina Court of Appeals issued *Arrowood I,* it also issued a unanimous opinion in a case that did involve Medicaid benefits, *Dillingham v. North Carolina Department of Human Resources*, 132 N.C. App. 704, 513 S.E.2d 823 (N.C.App. 1999). Judge Martin authored both the *Arrowood I* and the *Dillingham* decisions. Judge Lewis concurred with Judge Martin in *Arrowood I,* and Judge Walker dissented.

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

Three months later, the North Carolina Court of Appeals issued another unanimous decision involving the Medicaid Act. In *Duke Medical Center v. Bruton,* that Court ruled that the

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

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

More than a decade later, in *McCrann ex rel. McCrann v. Department of Health and Human Services*, any question about the need to promulgate changes in the State's Medicaid

program pursuant to the Administrative Procedures Act was put to rest. 704 S.E.2d 899 (N.C. 2011). In *McCrann*, as in Richard's case, the State received approval from CMS for the amendments to the Medicaid waiver program in question.[9] Id. 902. In a unanimous opinion, three different judges who had not been involved in the *Arrowood* or the *Dillingham* decisions distinguished the *Arrowood* case from the court's holding in *Dillingham*:

> Additionally, the *Arrowood I* dissent agreed with the holding in *Dillingham* that promulgation of a rule under the APA was required in that case in order for the rule to be valid.

Id. at 906. The court ruled that:

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

Id. Like Richard, the Medicaid participant in *McCrann* had not signed a written agreement, as had the plaintiff in *Arrowood I.* The court emphasized in *McCrann* that the Medicaid participant's knowledge of the changes simply "cannot equate" with the "contractual agreement" that existed in *Arrowood I."* ("Mere knowledge of the potential for denial of services is quite distinct from an agreement to be bound by terms explicitly set forth in a written contract.") The Court of Appeals ruled that to extend the holding of *Arrowood II* to the facts of this Medicaid case would "enact fundamental changes in administrative law." Id. at 906. That is exactly what would result if this Court should not reconsider its holding allowing DHHS to amend the Medicaid waiver without complying with the SC APA, or having the General Assembly enact a statute approving the changes. The unintended consequences of this ruling could be seismic and have far reaching unintended results across the State, thereby giving the Executive Branch

---

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

unfettered power in excess of that intended by the General Assembly of the State of South Carolina or the framers of the Constitution of the State of South Carolina. In *McCrann*, the court held that "Such a holding would be in stark contrast to the uniformity in this area of the law in jurisdictions across the United States. Id.

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

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

Id. 1226. Further, the court found in that case that "As the Human Services Board noted, there would have been no conflict over the Department's calculation of income if it had followed the APA throughout the process."[10] Id. 1228.

---

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

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

822 N.W.2d 616, 628, 297 Mich.App. 148 (Ct. App. 2012). After the State agency complied with the state's APA the parties settled this case. 828 N.W.2d 18 (Mich. 2013). DHHS could avoid continued litigation which has resulted from its ongoing violations of the APA by simply

As the North Carolina Court of Appeals recognized in *McCrann* that:

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

Id. at 907. The Court unambiguously held in *McCrann* that "*Arrowood* draws a clear line by which courts can recognize this exception - where the recipient of the benefits has contractually agreed to the terms of the waiver, obviating the need for further notice from promulgation of the rule in accordance with the APA."[11] In conclusion, the court held that "because the provision of

---

promulgating regulations establishing reasonable standards which are not arbitrary and capricious for the review of Medicaid State Plan and waiver amendments.

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

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

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

As did South Carolina, North Carolina reduced the service package provided by the Medicaid waiver program that serves persons with intellectual disabilities and related disabilities during FY 2010. But, those changes in North Carolina were enacted by the North Carolina General Assembly, unlike the changes at issue in *Stogsdill v. DHHS*, which were announced after the adjournment of the South Carolina General Assembly and put into place just prior to the beginning of the 2010 Session. *Pashby v. Cansler*, 709 F.3d 307 (4th Cir. 2023).

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

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

Conclusion

Richard is a young man who has demonstrated that he has been prejudiced by being subjected to five years of state administrative appeals, without certainty, all this time, that he will be able to remain in his own home. His non-disabled friends from high school are finishing

---

participant increased by more than $8,000 a year when the caps were put into place and other services were eliminated from the waiver program

collegiate studies, getting married and starting families. He asks in this administrative action to be provided the supports he needs to live at home, where he has lived since he was a young child, and to participate in the community. When Richard filed an administrative appeal in 2009, DDSN responded as they did in DHHS, attempting to reduce his Medicaid waiver services even further while he had an ongoing appeal. This is a violation of the Medicaid Act for the reasons set forth in *B.W. v. DHHS,* Exhibits 4, 5 and 6.

It has been documented by the South Carolina Legislative Audit Council that tens of millions of dollars (perhaps more) were spent by DDSN building up and buying segregated workshops with funds the General Assembly that were, instead, intended to provide home-based services in the community to people like Richard. R. 720 to 722. While other States were closing down segregated workshops, DDSN was wildly spending money, without authorization from the General Assembly, planning to send more persons who have disabilities, like Richard, to work in these warehouses. This Court may take judicial notice of the report issued by the National Protection & Advocacy System at http://www.ndrn.org/images/Documents/Resources/Publications/Reports/Segregated-and-Exploited.pdf, which describes the isolation and discrimination experienced in these twentieth-century "workhouses." By reducing the number of hours of services at home, the agencies knew that more waiver participants would be likely to "choose" this option. They had no other choice when the hours they received at home were cut.

The LAC Audit reported that DDSN spent just $7.6 million out of the $25.4 million allocated by the General Assembly to operate new beds in the community for the intended purpose. R. 720. When the agency did not spend the money as allocated, it lost the 70% matching

funds. Id. But DDSN officials told the LAC auditors that they "spent all of the funds appropriated for items related to the new beds." R. 722. Much of this money appears to have been spent on "day programs" and "other administrative functions" - including segregated workshop buildings across the State. Id. Some of this money was given to private corporations, some to local DSN Boards, without rhyme or reason, or any authorization by the Legislative Branch of Government. R. 722. This happened because there are no regulations requiring DDSN and DHHS to notify the public and the General Assembly before diverting millions of dollars for unintended purposes.

The 2008 LAC Audit of DDSN documented that the agency spent just $10,454 out of the $3 million in state dollars allocated to provide services for children with autism in FY 06. R. 723. The following year, in FY 07, the General Assembly allocated $7.5 million more, specifically to provide these services, but that year, only $661,463 was used for the intended purpose. Id. Those lucky enough to enroll in the program received an average of $15,000 per annum in services, while DDSN had been budgeted $37,000 per annum per PDD waiver participant (Medicaid waiver program for young children who have autism). Id. Had there been regulations requiring DDSN and DHHS to notify the General Assembly and the public when these funds were used for different purposes, the result might have been different.

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

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

The opinions of Richard's physician have clearly been given absolutely no deference in this case, in clear violation of *Olmstead*. DDSN employees who testified at Richard's second hearing admitted that they had not even reviewed his medical records or spoken with his doctor. Richard he has not received the services he requested in 2009, which were ordered by his physician, or even a final, appealable "fair hearing" decision on that request. More than five years ago, the DHHS hearing officer ruled that his need for services must be determined by "qualified" persons. DDSN maintained the hours he was receiving in Dec. 2009 - but it's taken five years to obtain judicial review of the decision to further reduce his services, below the amount he was receiving when he asked DHHS for a fair hearing. DHHS attempted, during the appeal, to reduce his services below the amount, duration and scope of services he needs to remain in the home. The Fourth Circuit has twice instructed DHHS and DDSN that Respite does not equal Res Hab (*Doe v. Kidd I and II, supra)*, nor can those services be adequately substituted for Personal Care services. DHHS has not only attempted to reduce Richard's Personal Care hours, but has ignored the holding of *Doe v. Kidd I and II* by attempting to provide lesser services "on the cheap."

The Medical Care Advisory Committee adopted waiver amendments on Aug. 18, 2009, after the General Assembly adjourned for the year. R. 821. The changes went into effect on January 1, 2010, before the General Assembly reconvened. Due to ARRA, the federal match rate

went from 70% to 79%. These changes were effective in Feb. 2009 - thus DDSN and DHHS was required to use significantly less than had been appropriated for FY 2009 to pay for Medicaid services. DDSN minutes from April 16, 2009 show that DDSN would receive an additional $28.8 million during FY 2009 due to ARRA. But, Deputy Director Kathi Lacy reported that "It was decided to cap some services that are most used by *people living at home* with their families..." R. 851. Sam Waldrep said that the services being removed were those with "low utilization." These numbers and justifications for the waiver amendments their explanations simply do not add up. The rationale used by agency officials could not be more arbitrary and capricious.

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

Respectfully submitted,

Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
plh.cola@att.net
S.C. Bar No. 0011309
Attorney for Richard Stogsdill

September 25, 2014

Exhibit 1

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

JURY,LC 1

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit 2

Nancy Stogsdill's Affidavit
September 25, 2014

AFFIDAVIT OF NANCY G. STOGSDILL

September 25, 2014

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

1. I am the mother of Richard S. who has lived in our family home since he was born.

2. Richard has profound cerebral palsy and he is unable to walk or get up out of the bed, he needs total assistance in toileting, bathing and dressing, he is unable to prepare food or to get a glass of water out of the faucet.

3. Richard has a history of terrible spasms in his legs that cause extreme pain. These come on without warning and we have to lift him out of his wheelchair and onto the bed to massage his legs until the pain goes away.

4. At the first hearing in 2009, we presented David Todd, a nurse who has worked with Richard for years and is very familiar with his condition and his medical needs.

5. Mr. Todd testified that the services Richard was receiving in 2009, when his school based services were reduced, were inadequate to meet his needs at home.

6. No qualified medical professional testified at Richard's first hearing and only his DDSN service coordinator had even met Richard before.

7. When Richard's father was living, both of us were totally exhausted from trying to provide the services he needs and now that his father is dead, I would not be able to keep Richard at home without significantly more support than is allowed under the waiver amendments.

8. Families did not know that DDSN and DHHS were planning this mass reduction in services until the very end of the legislative session in 2009 and the cuts took effect for everyone who did not file an appeal before the legislature reconvened.

9. Recently, Richard has been in and out of the hospital with kidney stones and these, too, cause terrible pain that the drugs that can be administered at home just can't control.

10. Richard wants to continue to live at home and to have opportunities to go out into the community and I want him to remain in the least restrictive setting.

11. Richard is totally opposed to entering an ICF/MR for residential services, or even for respite.

12. Richard would be unable to defend himself and he would not be safe at a workshop or a congregate group home setting.

13. Requiring Richard to sit around a table at a workshop watching persons who have cognitive disabilities do busy work would be tortuous to Richard.

14. When Richard was in school, he received one-on-one supervision during the school day and he was a valued member of the student body who had a lot of friends.

15. After he graduated from high school, Richard tried going to Vocational Rehabilitation to get a job.

16. They were not able to provide for his personal care needs there, and I would have to leave my job to take care of his toileting needs.

17. VR was unsuccessful in locating a job for Richard, so the hours of the day when he had been in school were not covered anymore.

18. I had to quit my full time job and now I have six part time jobs, so that I can run home between jobs and have more flexibility to be there when a caregiver is absent.

19. DDSN never told us that having adult companion services was a feasible alternative under the waiver to the workshop, or how to access those services.

20. It took months (more than 90 days) after the first hearing officer ordered DDSN to provide companion services before they were put into place and they have been very sporadic due to the rate of pay and the failure to enlist sufficient providers of this service.

21. If the PCA/Adult Companion combined cap were to be imposed on Richard, he would no longer have access to his companion.

22. Richard's father became ill in 2012 with cancer and he was unable to help me take care of Richard prior to his death a year ago.

23. When Richard's father was very ill, DDSN provided some additional respite hours, but they refused to exceed the respite cap established in 2010 or to provide additional PCA hours.

24. The only alternative DDSN offered was to place Richard in an ICF/MR in a large regional center, where he would be segregated from non-disabled persons and would be isolated from his family.

25. My service coordinator told me that we were capped at the number of PCA hours Richard

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

26. Physical therapy, occupational therapy and speech services are included Richard's 2012 plan of care, but they have not been provided. Exhibit 20.

27. Since Richard's father died and I no longer have the support he provided prior to his illness, Richard has been repeatedly hospitalized and has been in tremendous pain.

28. I am exhausted now from caregiving responsibilities and, if Richard's services are cut, he will likely have to move from our home, which breaks my heart to think how traumatized and isolated he will feel.

29. I am getting older and I am just not able to lift and to hold up the way I could when I was younger.

30. I have a friend who served on the Kershaw County DSN Board with me whose son has disabilities similar to Richard's.

31. She attempted to appeal the reductions in her son's services, but when it became clear that DHHS intended to impose them, she was forced to place him in a nursing home, where he is the youngest resident by many, many years.

32. Her son's condition has declined terribly in the nursing home, since he moved out of his home, and he has developed decubitus ulcers and infections.

33. My biggest fear in life is that this could happen to my son. This parent, like me, always believed that her son would always live at home, and it is impossible for parents like us to allow our minds to imagine what it would be like for our children if they were sent to live in an institution with only old and disabled persons.

34. Parents are afraid of retaliation and Richard's psychological services provider was terminated soon after she signed an affidavit in support of Richard and advocated for exemptions to these service caps for other persons.

35. If Richard's services were to be cut, I would be faced with draining my retirement savings to take care of him, or placing him in an institution, where taxpayers would pay more than the cost of his care at home, but I would not be responsible for his costs there.

36. Richard's doctor has said that his mental and physical health would deteriorate if he were to be placed in a congregate setting and I know my own limits and totally agree with that assessment.

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

Nancy Stogsdill

September 25, 2014

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

Notary Public for South Carolina
My Commission Expires: August 14, 2015

Exhibit 3

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

RECEIVED APR 3 0 2013

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

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

JURISDICTION

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

STATEMENT OF THE CASE

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

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

FINDINGS OF FACT

(1) Via Final Administrative Decision of June 5, 2006, this Hearing Officer affirmed Respondent's determination that the Petitioner no longer met the Intermediate Care Facility for the Mentally Retarded (ICF/MR), Level of Care (LOC) criteria and; therefore, was not eligible to receive Medicaid services under the Mental Retardation/Related Disabilities (MR/RD) Waiver program.

(2) This Hearing Officer's Final Administrative Decision was appealed to the South Carolina Administrative Law Court. Via Order dated June 28, 2007, State of South Carolina Administrative Law Court Judge, Paige J. Gossett directed this Hearing Officer to make a determination as to the Petitioner's interim care until Judge Gossett made her final decision on Petitioner's appeal.

(3) Via Order of July 30, 2007, this Hearing Officer determined that the Petitioner would be moved to another Community Training Home II (CTH II) that is qualified to provide those services that Respondent has determined the Petitioner requires, and furthermore, the Petitioner's new CTH II would be as close as possible to the Petitioner's home.

(4) With no evidence to the contrary, Petitioner never appealed this Hearing Officer's July 30, 2007 Order.

(5) Via Order of June 20, 2008, State of South Carolina Administrative Law Court Judge, Paige J. Gossett affirmed this Hearing Officer's determination which found the Petitioner no longer eligible for MR/RD Waiver Medicaid services as she did not meet the ICF/MR level of care criteria.

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

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

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

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

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

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

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

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

> This subpart--
> (a) Implements section 1902(a)(3) of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly;
> (b) Prescribes procedures for an opportunity for a hearing if the State agency or PAHP takes action, as stated in this subpart, to suspend, terminate, or reduce services, or an MCO or PIHP takes action under subpart F of part 438 of this chapter; and....

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

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

DECISION

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

AND IT IS SO ORDERED.

Robert French
Chief Hearing Officer

Dated at Columbia,
South Carolina

April 28, 2013

Exhibit 4

B.W. v. SCDHHS
Appeals Case # 07-MISC-028(Remanded)
Final Administrative Order
November 19, 2013

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

JURISDICTION

Procedure in this case is governed by the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services to administer various programs and grants (See e.g., S.C. Code Ann. § 44-6-10, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (27 S.C. Code Regs. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. § 1-23-310, et seq.).

BACKGROUND

The Petitioner in this matter was injured in an automobile accident in 2005, which rendered her quadriplegic. At the time of the accident, the Petitioner was 17 years old. She has difficulty speaking due to subsequent injuries to her larynx sustained during her initial hospitalization. She breathes through a tracheostomy. The Petitioner became eligible for Medicaid-covered services shortly after the accident. Since her May, 2007 return home, she has been receiving services under the South Carolina Head and Spinal Cord Injury (HASCI) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through the South Carolina

Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which, by getting the federal agency to "waive" certain generic requirements of the Medicaid program, States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. This and other Waivers operated by SCDDSN are for home and community based services under Section 1915(c) of the Social Security Act [42 USC §1396n(c)]. These types of Waivers allow services to be provided in the home or community, in lieu of institutional services. The South Carolina Department of Health and Human Services (SCDHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and is responsible for the overall administration of the Waiver.

In February 2007, in anticipation of the Petitioner's discharge home from her initial hospital stay, the Petitioner's Service Coordinator (Ms. Gosnell, at that time) completed her Service Plan. The parties disputed several aspects of that plan including the nursing and service hours to be provided to Petitioner upon her discharge home. That dispute forms the basis of the present appeal. There are three types of services at issue in this case:

1. RN services, where a registered nurse can provide nursing care, complete certain medical tasks, and assess the Waiver Participant;
2. LPN services, where a licensed practical nurse can provide nursing care and complete certain medical tasks;
3. Attendant care services, where a qualified provider can help with activities of daily living such as light housekeeping, feeding, clothing, or bathing. Only an RN, LPN, or trained family member can provide skilled care.

In 2007, this matter was originally before the Appeals Division of the SCDHHS, but was dismissed, essentially for confusion about joinder of the issues. Thereupon, the matter was

appealed to the Administrative Law Court (ALC) which remanded the matter for an evidentiary hearing at SCDHHS. After the hearing (April 14, 2009), the SCDHHS Hearing Officer's Decision, issued on July 9, 2009, was appealed and, on July 30, 2012, the ALC once again remanded the case to the SCDHHS Appeals Division for a determination of the five issues listed below.

A hearing was held over two days: October 25, 2012 and October 31, 2012 at the SCDHHS Offices. Richard Hepfer, Esquire, represented Respondent and called as witnesses: Dr. Linda Veldheer, SCDDSN, Director, HASCI Division; Anita Atwood, SCDHHS, HASCI Waiver Administrator; Zanipha Mohammed, SCDHHS, Durable Medical Equipment; and Ashley Wingo, the Petitioner's current Service Coordinator. Patricia Harrison, Esquire, represented the Petitioner and called as witnesses: Sandra Ray, Speech Pathologist and Rhonda Galus, the Petitioner's LPN. In addition to the testimony of the witnesses, I have Declaration Statements from the Petitioner, her mother, S.W., her father, J.W., and Kathy Hoover, RN. Additionally, I have affidavits of Don Kovach of Dynavox Mayer-Johnson and Lennie Mullis.

The following documents were admitted as exhibits for the Petitioner:

1. A 9/24/2012 letter from Linda Veldheer to Petitioner indicating that, if the Petitioner approved, her services would be restored to the May 2007 levels;
2. Charles Lea Center's Estimated Annual cost of services for Petitioner for 2010, 2011, and 2012;
3. A 3/14/2007 Notice of Denial of an apparent request for additional nursing services;
4. A 3/30/2007 Notice of Denial of an apparent request for additional nursing services;
5. A 3/29/2007 Physician's Order for Petitioner for 28 hours per week of RN and 84 hours per week of LPN services, and a companion letter from Dr. Silvestri;

6. Various DDSN Manual provisions;

7. A March 18, 2010, Discharge Summary from Greenville Hospital System;

8. The Service Coordinators' Record of Contact for the Petitioner dated for various times between 12/1/09 – 09/27/12;

9. DDSN HASCI Form 15 (9-10) dated 2/22/12 by Dr. Katherine Lumpkin;

10. ICD-9 Description of the E2510 Speech Generating Device;

11. Telephone Declaration of J. W. taken by Petitioner's attorney;

12. Telephone Declaration of B. W. taken by Petitioner's attorney;

13. Telephone Declaration of S. W. taken by Petitioner's attorney;

14. Affidavit of Don Kovach;

15. Declaration of Kathy Hoover, RN;

16. Attachments to Declaration of Kathy Hoover, RN;

17. Section 2 of the Home Health Services Manual, updated 10/01/12;

18. Section 2 of the Private Rehabilitation Therapy and Audiology Services Manual, update 10/01/12;

19. An August 20, 2010, News Release from the Comptroller General's Office about the budget challenges of FY 2010;

20. A May 8, 2009, cover letter enclosing documentation about the request for the speech generating device;

21. Affidavit of Lennie Mullis;

22. Packet of documents regarding the requested speech generating device;

23. Detailed Claims Report of Petitioner dated 10/16/2012;

24. Personal Care Needs Form, no date, for B.W.;

25. DDSN Annual Accountability Report, FY 2011-2012;

26. Document entitled Head and Spinal Cord Injury (HASCI) Waiver Recommendations for Revised Service Limits, Attachment D;

27. DDSN Service Coordination Manual, Revised July 1, 2011;

28. Documents from a Nursing Services Review of Petitioner by Vivian Koon; and

29. Photographs of Petitioner.

The following documents were admitted as exhibits for the Respondent:

1. Documents related to the original request for a speech generating device; and

2. The Current HASCI Waiver document.

In addition to the exhibits listed above, the 120 page record of the 2007 attempted appeal along with the 1,582 page record of the 2009 fair hearing were also a part of the record in the current matter. Note that the undersigned Hearing Officer was new to this case in 2012 as the Hearing Officer who presided over the 2007 and 2009 matters is deceased.

ISSUES

The Administrative Law Court has remanded this appeal to determine the following issues:

1. The weekly hours of registered nursing that are needed by the Petitioner, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.

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

3. The number of hours of the authorized care described in #2, above, that has been provided by the mother (according to her qualifications), and the cost of that care, which amount shall be paid to the mother.

4. In the future, the mother should be allowed to provide whatever care she is qualified to provide within the authorized hours of service set as described in #2, above, and shall be paid for such services at a rate to be determined upon remand.

5. The cost of an average digital speech device of the type described by Dr. Burton shall be determined and paid to the Petitioner to defray the cost of the more expensive device she purchased.

HISTORY OF SERVICE HOURS DISPUTE

The Service Plan drafted by the Petitioner's Service Coordinator in February 2007 required 28 hours per week of Personal Care Aide (PCA) services; 56 hours per week of nursing care provided by a Licensed Practical Nurse (LPN); 14 hours per week of nursing care provided by a Registered Nurse (RN). The RN services were to be evaluated after 30 days but continue in some amount per week. The care to be provided under this Service Plan totaled 98 hours per week. However, the Petitioner's treating physicians ordered 28 hours per week of RN services; 84 hours per week of LPN services for a total of 112 hours of skilled care per week. The treating physician also ordered attendant care whenever a nurse was not present. Presumably the attendant hours would be covered by the Petitioner's parents as the Petitioner's mother was the only attendant available that could provide skilled care. The Petitioner remained hospitalized as the parties continued to negotiate the Petitioner's care upon discharge. B.W. v. SCDHHS, Docket No. 09-ALJ-08-03440AP (S.C.A.L.C. July 30, 2012).

On March 14, 2007, DDSN issued a HASCI Notice of Denial form notifying the Petitioner that Medicaid Waiver Nursing Services were denied for exceeding service limits. "B___ will already be receiving the maximum number of RN hours per week (44) and can not receive additional hours of LPN services according to the HASCI waiver guidelines. The HASCI waiver manual specifically states: The maximum number of nursing services/units that can be funded by the HASCI waiver is 60 hours per week provided by an LPN-OR-44 hours per week provided by an RN." Petitioner's Exhibit 3. This notice did not include any reference to a supporting statute or regulation as a basis for this decision nor did the notice provide any information regarding the continuation of benefits pending an appeal. The Petitioner was under 21 at the time this notice was issued. This notice was sent to the Petitioner's home even though she was hospitalized at this time. Although the notice cites a maximum number of nursing hours, according to the Director of the HASCI Waiver, Dr. Linda Veldheer, there were no limits under the Waiver at this time. Instead, this notice was following "HASCI Waiver procedures." T. at 60. At this time HASCI did not have caps that were part of the Waiver document but SCDDSN was following "limits we were applying at the direction of HHS." Id.

On March 29, 2007, the Petitioner's treating physician, Dr. Silvestri, ordered 84 hours per week of LPN care; 24 hours per week of RN care and attendant care at all times when the nurse was not present. On March 30, 2007, DDSN sent a denial notice stating that due to the Medicaid Waiver, the ordered Nursing Services exceeds service limits: "HASCI Waiver services (home and community based services) can not be offered when it can reasonably be expected that the cost of services to B___ would exceed the cost of a nursing facility level of care." Petitioner's Exhibit 4. Again, no statute or regulations were cited on this notice nor was there any justification or analysis regarding whether the cost for this care would be greater than the cost of

a nursing home. Ms. Atwood testified that the Waiver limits looked at the aggregate cost of institutional vs. non-institutional care and that there were no caps applied to individuals. T. at 10-14. Dr. Veldheer testified that it would be improper for a denial to be based on the individual's service costing more than nursing home care since there are no individual limits. T. at 57. The Petitioner was under 21 at this time. This notice made no mention of continued benefits pending appeal. Like the previous notice, this notice was also sent to the Petitioner's home although she was still hospitalized at MUSC.

The notices sent to B.W. refer to limits within the HASCI Waiver. However, the Respondent presented conflicting testimony regarding whether there was in fact a limit within the HASCI Waiver at this time. According to Ms. Atwood, the HASCI Waiver Administrator for SCDHHS, there were no limits on nursing and attendant care services within the HASCI Waiver prior to July 2008. T. at 6. Dr. Veldheer asserted that SCDDSN applied limits to HASCI Waiver participants in 2007. T. at 61. Dr. Veldheer explained that, although there were no limits in the Waiver document at this time, "we were applying those kinds of limits informally." T. at 42. Dr. Veldheer claimed that in spite of the language contained in the March 30, 2007 notice, SCDDSN was not applying an individual limit. She seemed to indicate the notice is a local issue: "The service coordinator wrote this comment. I don't agree with this comment but this is what a service coordinator at the local level wrote." T. at 61. In rebuttal testimony, Dr. Veldheer contradicted her earlier statement and testified that the HASCI Waiver did not have an individual limit at the time the 2007 notices were issued. T. at 243.

On April 28, 2007, while still hospitalized, the Petitioner requested the present appeal due to the denial of the nursing and attendant care services ordered by her treating physicians. The

Petitioner was discharged on May 8, 2007, and was to receive the services that had been included in the service plan created by the Service Coordinator in February 2007.

On May 9, 2007, the day following the Petitioner's discharge from the hospital, she sent a letter to SCDDSN and SCDHHS stating she "...reserves all rights. Her acceptance of services in order to secure her release from her current, considerably more expensive institutional placement cannot be construed as a waiver, consent, limitation, estoppel, or other indication of agreement with the restrictions imposed by SCDDSN and SCDHHS." Record of 2007 Matter at 58.

In July 2008, while this appeal was pending, the Respondent reduced the Petitioner's service hours to 32 hours per week of LPN and 48 hours per week of attendant care plus seven hours per month of respite care. T. at 44. There is no notice in the record regarding this service reduction. This reduction occurred while the current appeal was pending and while the Petitioner was under 21. Dr. Veldheer testified that in July 2008, services were limited to 60 hours of LPN per week or 45 hours of RN per week or a combination not to exceed $1,425 based on an LPN rate of $23.75 per hour; RN rate of $31.35 per hour. T. at 43. However, when asked about this weekly limit on cross examination, Dr. Veldheer asserts, "I never said that...We've never had weekly limits." T. at 66. According to Ms. Atwood, there were no limits on nursing services or attendant care prior to July 2008. T. at 6. The Petitioner was still not receiving RN services due to the Service Coordinator's inability to locate an RN and the mistaken idea that the RN could only provide 2 hours of care per day.

In July 2009, while this appeal was pending, the Petitioner's nursing hours were again reduced. Her LPN hours were brought down to 22 hours per week while the attendant care was increased to 48 hours per week along with 12 hours per week of respite care. T. at 45. There is

no notice in the record regarding this reduction. As with the 2008 service reductions, the 2009 reductions occurred while the current appeal was pending.

In 2010, the HASCI Waiver was renewed and an across the board cut was instituted. There was no individual assessment to determine whether the cuts were appropriate, no cost analysis to determine if less expensive services could be used, nor any medical review of the consequences of the cuts. T. at 20-21and 25. At this time, Petitioner's services remained the same (22 hours per week LPN and 48 hours per week attendant) as the 2009 reduction had already put her services within the across the board cuts. T. at 45. According to the Respondent, since 2010, the combination of nursing and attendant care cannot exceed 70 hours per week (10 hours per day). Prior to 2010, there was a 12 hour per day limit (total limit of 84 hours per week).

In 2011, Petitioner's services went to 34 hours per week of LPN, 36 hours per week of attendant care, and 12 hours per week of respite care. This is the Petitioner's current authorization and is the Waiver limit for the combination of attendant care and nursing, according to Dr. Veldheer. T. at 45.

Prior to the hearing, the Respondent sent the Petitioner a letter offering to restore her HASCI Waiver services to the levels of May 2007 which the letter characterized as: 2-3 hours per week of RN services, 8 hours per day of LPN services, 4 hours per day of attendant care, physical therapy (P.T.), occupational therapy (O.T.), speech therapy (S.T.), and Psychological services. Petitioner's Exhibit 1. This offer totaled 83-84 hours per week of skilled and attendant care which exceeds the current waiver limits. The timing of the letter indicates that it was sent in an attempt to settle this dispute.

At some point while this appeal was pending, the Petitioner's parents divorced and the Petitioner's mother, S.W., became the Petitioner's sole caregiver.

Issues 1 and 2 will be considered together as the facts and law are inter-related.

Issue 1 - The weekly hours of registered nursing that are needed by the Petitioner, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.

Issue 2 – How many weekly hours of each type of care and services have been needed by Appellant during the course of her treatment since her discharge from the hospital in May 2007 consistent with the Medicaid Program, and the principal that the mother is not legally responsible for caring for the Appellant.

DISCUSSION

At the time of the Petitioner's return home in 2007, her Service Plan called for two hours per day, seven days per week of RN care; however, the Service Coordinator was unable to find an RN in the area willing to work a two hour shift and those care hours went unfilled. As the limited daily hours appeared to be a roadblock to getting the Petitioner the RN services to which she was entitled, the Petitioner's parents asked the Service Coordinator whether they could combine the 14 hours per week so that an RN could provide services for longer periods of time over fewer days. The Service Coordinator informed the family that it was not possible to combine these nursing hours under the Waiver and that they must use two hours per day. Petitioner's Exhibit 13, Declaration of S.W. at 6. However, two witnesses for the Respondent, Ms. Atwood and Dr. Veldheer, acknowledged that Waiver participants can combine nursing hours. T. at 20 and 82. Both parties agreed that it is not possible to find an RN who would work a two hour shift. T. 199-200 and 221. Dr. Veldheer testified that because it is difficult to get an

with nursing needs will receive. T. at 226-227. The centralized nurse can determine whether a service is medically necessary. T. at 22.

Dr. Veldheer stated that if a treating physician ordered nursing hours that exceeded waiver limits, the SCDDSN centralized nurse would not give any deference to that medical order. Dr. Veldheer explained that the form used by SCDDSN does not allow the doctor to designate a recommended number of nursing hours. The doctor identifies the condition and the specific skilled nursing care they require. If the doctor ordered hours that exceeded limits, the centralized nurse would "not consider it." T. at 232.

The Respondent has not presented any medical witnesses with direct knowledge of the Petitioner's condition at either of the two hearings in this matter. The Respondent's Medical Director, Dr. Marion Burton, testified during the 2009 hearing. Dr. Burton had not met the Petitioner prior to the 2009 hearing. He was "somewhat familiar" with the case. Record of 2009 Matter at 47-48. Although Dr. Burton could not recall the specific details of the care the Petitioner was to receive upon discharge from the hospital, he believed she was to receive about 50 hours of skilled care per week and that, along with the supporting care of the parents and attendant care, was adequate to maintain the Petitioner at home. *Id.* He has no training in the treatment of head or spinal cord injuries and admitted that he was only vaguely familiar with the HASCI Waiver program. Record of 2009 Matter at 92-93. Dr. Burton admitted that he did not have the expertise to override the orders of a treating physician. His decision to deny services was based upon Department guidance and the SCDHHS provider manual policy. Record of 2009 Matter at 97, 109-111.

Tracheostomy in place – tracheoesophageal fistula

Dysphagia – GERD

Hypothyroidism

Staph coag negative bacteremia – treated with Rocephin"

Petitioner's Exhibit 28 at 2.

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

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

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

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

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

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

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

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

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

I therefore find:

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

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

3. The Petitioner's Service Plan also authorized 56 hours per week of LPN care and 28 hours of Attendant care.

4. The denial notices that were issued to the Petitioner prior to her initial discharge from the hospital were improper as they did not contain the statutes or regulations the actions were based upon nor did they provide instruction on how to appeal the negative action. The denial notices were sent to the Petitioner's home, although she was hospitalized at the time. Additionally, the reasons for the denials given in these notices were erroneous according to the testimony of the Respondent. The Petitioner was under 21 at the time that the denial notices were issued. The Petitioner turned 21 on January 14, 2009.

5. While pending the resolution of this appeal, the Petitioner's services were improperly reduced several times. The reductions occurred without notice and the opportunity to appeal. The reduction in 2008 occurred before the Petitioner turned 21.

6. In July 2008, the Petitioner's hours were reduced to 32 hours of LPN and 48 hours of attendant care (total of 80 hours per week). There was no notice provided to the Petitioner for this reduction.

7. In 2009, the Respondent again improperly reduced the Petitioner's service hours to 70 hours per week of combined LPN and Attendant Care. This reduction occurred during the pendency of this appeal. The Respondent again failed to provide proper notice.

8. At some point after the Petitioner was discharged from MUSC in 2007, her father moved out of the home and the Petitioner's mother became the sole family member providing

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

9. Upon discharge on May 9, 2007, the Petitioner was unable to find a provider of RN services willing to work the authorized hours per week and thus was unable to fill the position. The inability to locate a suitable RN was due to the Service Coordinator's erroneous assertion that the Petitioner could only receive RN hours in daily two hour increments. The Petitioner and her family relied upon this erroneous assertion. The Petitioner still has not received RN hours in her home since her initial discharge from the hospital in 2007.

10. During the pendency of this appeal, the Petitioner's mother has provided all of the care that the Respondent failed to provide due to both miscommunication and service reductions.

11. Witnesses for both parties concur that it is not possible to locate an RN who would be willing to travel to work for such a short period each day. The Petitioner and RN provider should have had the opportunity to schedule the RN hours so that the schedule best met their mutual needs.

12. The Petitioner was not re-evaluated 30 days after her initial discharge from the hospital to determine whether the 14 hours per week of RN should continue.

13. Under the current nursing hours review process, the Respondent does not seek the recommendation of the treating doctor regarding nursing hours needed by HASCI Waiver participants. The current authorization process for nursing hours requires a centralized SCDDSN nurse to perform a record review.

14. The Respondent has not provided any records which indicate that a physician for the Respondent has ever reviewed the Petitioner's medical needs.

15. The medical records review conducted by the Respondent and the testimony of witnesses for both parties indicate that the Petitioner is a quadriplegic, who relies upon a tracheostomy to breathe, and suffers from several complicated medical conditions including recurrent pneumonia, seizures, and skin break down. Due to her condition, she is at continued risk for infection. She requires constant care and cannot be left alone. Based on the testimony of witnesses for both parties, an RN should have been involved in the Petitioner's care on at least a weekly basis due to the complexity of the Petitioner's medical needs.

16. The Respondent relied upon the evaluation of a nurse to determine the hours of skilled care needed by HASCI Waiver participants.

17. An RN can assess the Petitioner's lung functioning, skin condition, and infection risks. According to the testimony of both parties, the Petitioner would benefit from a weekly assessment conducted by an RN.

18. Due to the Petitioner's complicated medical conditions and her dependence upon a single caregiver, she should receive the maximum services available under the HASCI Waiver. For this Petitioner, a four hour block of RN services is the minimum necessary per week. However, under the current rules, the Petitioner may adjust the nursing hours between RN and LPN services. The Petitioner may therefore receive up to a maximum of 45 hours per week of RN care should she so choose, bearing in mind that limit works in tandem with the limits for LPN services and an increase in RN hours may result in a

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

19. The Petitioner would have benefitted from 14 hours of RN care per week through June 30, 2007, and at least four 4 hours of RN services with increased RN, if the Petitioner had desired, up to the waiver limit. The Petitioner should have received RN services weekly through the present time. The Petitioner has been maintained at home with fewer services than those to which she was entitled due to the extraordinary efforts and dedication of her mother.

20. The Petitioner's benefits should have continued at the levels ordered by her treating physician during the pendency of this appeal.

21. There are RNs available in the Petitioner's service area who will cover four hours or more of care per week.

LEGAL DISCUSSION

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

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

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

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

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

4. Should the Petitioner experience a change in circumstances, including a worsening of her condition, she can seek additional service beyond the Waiver limits. Should she experience a service reduction, the Respondent shall provide notice and an opportunity for a hearing.

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

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

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

I therefore find:

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

6. The Petitioner's mother provided attendant care services to the Petitioner. The parties are in agreement that the current payment rate for Attendant Care is $11.10.

7. The Petitioner's mother is entitled to reimbursement for the care that she provided as follows:

Hours for Which Petitioner's Mother Shall Be Compensated

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

CONCLUSIONS OF LAW

1. At all times during this appeal the Waiver provisions allowed the parents of adult children to serve as paid caregivers to those children according to their training and qualifications (Record of the 2009 Matter at 766.)

2. The rate specified for attendant care providers under the Waiver at all times during this appeal has been $11.10.

3. The Petitioner's mother shall be reimbursed by the Respondent in the amount of $140,148.60 for the care that she provided. The Respondent shall reimburse the Petitioner's mother within 30 days of the date of this Order.

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

DISCUSSION

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

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

CONCLUSIONS OF LAW

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

2. Changes to the pay rate which impact other attendant care providers will also be applied to the Petitioner's mother.

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

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

DISCUSSION

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

2. The Respondent shall reimburse the Petitioner's mother within 30 days of the date of this Order.

3. Whether the cost of the device is covered by the Waiver or by the State Plan is irrelevant to my decision and shall be determined by the Respondent and its agent, SCDDSN. That determination shall not impact or delay the reimbursement of the $8,318.80 owed to the Petitioner's mother.

4. This Order does not prevent the Petitioner from seeking the difference between the amount awarded here and the actual cost her family incurred. Nor does this Order prevent the Petitioner from seeking an assessment for a new speech generating device or a replacement speech generating device in the future. Should a future medical order for a speech generating device by the Petitioner's provider be denied or reduced by the Respondent, the Respondent shall send the Petitioner notice of such denial or reduction allowing the Petitioner the opportunity to appeal.

DECISION

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

2. The Petitioner's mother may provide some of the hours of care required under the Petitioner's Service Plan. If the Petitioner's mother provides such care, she shall be paid for that care at the rate for Attendant Care Services (currently $11.10 per hour).

3. The Petitioner's mother shall be repaid in the amount of $140,148.60 for the care she provided to the Petitioner during the pendency of this appeal. This amount shall be paid to the Petitioner's mother within 30 days of the date of this Order.

4. Within 30 days of the date of this Order, the Respondent shall reimburse the Petitioner's mother $8,318.80 for the cost of the speech generating device.

Any issues not addressed in this Order are deemed dismissed.

AND IT IS SO ORDERED.

Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina
November 19, 2013

Exhibit 5

B.W. v. SCDHHS
Appeals Case # 07-MISC-028(Remanded)
Order Denying Reconsideration of
Final Administrative Order of November 19, 2013
December 23, 2013

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

BACKGROUND

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

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

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

(Respondent's Motion for Reconsideration at 4)

DISCUSSION

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

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

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

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

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

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

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

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

ORDER

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

AND IT IS SO ORDERED.

Elizabeth B. Hutto

Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina

December 23, 2013

Exhibit 6

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

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Brook Waddle,
Appellant/Respondent,

v.

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

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

PETITION/COMPLAINT FOR REMEDIAL WRIT

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

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

FILED
JUN 23 2014
SC ADMIN. LAW COURT

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

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

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

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

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

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

Petition at 3.

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

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

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

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

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

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

> Rule 34. Automatic Stay of Proceedings Upon Appeal
>
> The filing of an appeal from the final decision of an agency shall stay the final decision of that agency unless the effect of filing an appeal is otherwise established by statute, the Administrative Procedures Act notwithstanding; or the administrative law judge has entered an order regarding the effect of the proceedings in the agency. Notwithstanding the foregoing, upon the filing of an appeal from the final decision of an agency, any party may apply to the administrative law judge for an order regarding the effect of the appeal on the agency decision.

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

---

[1] Rule 65(f)(1) provides that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

R. at 921.

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

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

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

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

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

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

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

---

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

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

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

Brook faces this same irreparable harm.

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

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

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

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

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

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

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

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

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

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

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

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

---

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Peter B. v. Sanford. Exhibit 6.

---

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

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

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

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

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

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

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

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

(3) There is no adequate remedy at law.

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

CONCLUSION

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

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

As Brook requested in her May 1, 2014 Petition:

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

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

Respectfully submitted,

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

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

June 20, 2014

---

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

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

VERIFICATION

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

Brook Waddle

Sandra Waddle

Sandra Waddle, Attorney in Fact

SWORN TO BEFORE ME THIS
20 day of June, 2014.

Notary Public for South Carolina

My Commission Expires

LIST OF EXHIBITS

1. November 19, 2013 Order of DHHS Hearing Officer Hutto

2. December 23, 2013 Order of DHHS Hearing Officer Hutto

3. May 1, 2014 Petition filed by Appellant in ALC

4. Affidavit of Sandra Waddle

5. Affidavit of Lennie Mullis

6. Peter B. v. Sanford, Report and Recommendation of Magistrate Judge

7. South Carolina Administrative Practice and Procedure Excerpt

8. "*To Stay or Not to Stay: Automatic Stays Before the Administrative Law Court in DHEC Matters,*" published in the September 2008 South Carolina Lawyer

9. November 2008 Letter from CMS to DHHS approving waiver costs

10. November 2009 Letter from CMS to DHHS approving waiver costs

STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Carolyn C. Matthews, Administrative Law Judge

RECEIVED
SEP 2 3 2014
SC Court of Appeals

Case No. 10-ALJ-08-0774-AP

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent

---

MEMORANDUM IN SUPPORT OF PETITION FOR REHEARING

The court should rehear the matter in order to set forth the standard for determining the level of risk of institutionalization necessary for there to be a finding that elimination of services is violative of the integration mandate, originally set forth in Olmstead v. L.C. ex rel Zimring. 527 U.S. 581, 119 S.Ct. 2176, 144 L. Ed.2d540 (1999). Furthermore, the weight of the uncontroverted evidence in the form of Affidavits, does not show that the Appellant is at sufficient risk of institutionalization to meet the proper standard of serious or significant risk as established in this federal circuit.

The court based much of its opinion on the case of Pashby v. Delia, 709 F. 3d 307 (4th Cir. 2013), which sets a standard of "significant risk" of institutionalization. Pashby, at 322. Furthermore, the court in Pashby was "especially swayed by the Statement of the Department of Justice on the Integration mandate of Title II of the ADA and Olmstead v. L.C." The standard in that Statement is "serious risk of institutionalization." Therefore, in this circuit, the standard must be "serious" or "significant" risk of institutionalization. The standard in M.R. v. Dreyfuss, 697 F. 3d 706 was "serious" at 720, 726, 732, & 739. The standard in Fisher v. Okla. Healthcare Auth., 335 F.3d 1175, at 1184, was a "high risk for premature entry into a nursing home." The level of risk of institutionalization was not an issue in the Radaszewski ex rel Radeszewski, 383 F.3d 599 (7th Cir. 2004) or Rodriguez v. City of New York, 197 F.3d 611 (2nd Cir. 1999) cases cited in this opinion.

The point is that any Waiver participant is always at "risk" of institutionalization no matter what services are in place. The need for institutionalization is the basic criteria for entrance into the program. See Appendix B-6(c) of the ID/RD Waiver Application at https://www.scdhhs.gov/sites/default/files/SC.0237.R04.04%20ID%20RD%20AMENDED%20CMS%20APPROVAL%202014.pdf.

Under this provision, an individual must meet the level of care criteria for Medicaid Sponsored admission to an Intermediate Care Facility for the Intellectually Disabled (clearly an institution). Taken to its logical conclusion, then, any reduction in services would place any participant at some risk of institutionalization.

The question in this case should be whether, back in 2010, elimination of services down to the maximum allowed under the Waiver at that time put the Appellant at "serious' or "significant" risk of institutionalization. In the January 2010 Waiver renewal PCA and attendant services were limited to a combined total of 28 weekly hours of, but availability of Respite care was increased to a maximum of 240 hours per month. Therapies were eliminated under the Waiver, but were still available under the State Plan. In addition, the services listed in Appendix C-1(a) of the Waiver document, as appropriate would be available. Even though it had not been tried by the Appellant, Employment Services (workshop) were ruled out by his physician and his psychological services provider. See Affidavits, at R., pp. 917 & 920. The Appellant also would not try institutional respite services, which would give his caregiver blocks of free time. See, testimony of mother at R., p. 329. Presumably, he would also be unwilling to attend Adult Day Health Care for part of the day. There he would receive constant monitoring and care, but he would have to be in a setting with the intellectually disabled.

Although the affidavits presented were determined by the court to set forth a quantum of proof that "...exceeds that offered by the plaintiffs in Pashby," we are unable to see that in the affidavits. In the Pashby case the declarants, who were the Recipients and people familiar with their cases, made statements that the Recipients "may," "might," "probably" would or were "likely" to enter [an institution]. Pashby, at 322. The affidavits in this case state as follows:

1. The Affidavit of Lennie Mullis (R., p. 917): This affidavit primarily focuses on the Appellants psychological state as he ended his Vocational Rehabilitation

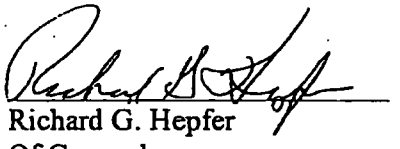
program. It says that a combination of personal care, companion and respite services is needed, but it defers to the appellant's treating physician to determine the number of hours needed for the Appellant to remain in the community.

2. The Affidavit of Dr. Joseph (R., p. 920): This affidavit says what the Appellant needs in terms of services. It does say that the Appellant would regress if the services were reduced; it does say that the burden on his parents would be greater; it does say that he would be "at risk" of institutionalization if the needed services are not provided; but it does not specify or explain that the risk is a serious or significant level of risk.
3. The Affidavit of the Appellant (R., p. 923): This affidavit does say that the recent changes (presumably the waiver limitations) will prevent people like him from remaining in their homes.
4. In an e-mail exchange with a DDSN Board member (R., p. 926) The Appellants mother says that cutting services would require her son to be put in an institution. Yet in testimony (R., p. 329) she could not imagine the Appellant being in institutional respite even for a short time

In sum, the professional providers, do not say that the Appellant would be at serious or significant risk of institutionalization if the services were limited. Furthermore, In this case, there has been no direct testimony by any of the Petitioner's attending providers. Although an attending physician's affidavit was entered into the Record (R. p. 920-922) as was the Appellant's psychological provider's affidavit, at R. p. 917-19, for their probative value (R. p. 313), they are still fundamentally hearsay

evidence. Since the hearing in this case, the Supreme Court has clarified the issue of hearsay evidence in administrative hearings, including probable cause hearings. The Court found that the Rules of Evidence, which are applicable in administrative hearings, expressly exclude the hearsay testimony. South Carolina Dept. of Motor Vehicles v. McCarson 391 S.C. 136, 705 S.E.2d 425 (S.C. 2011).

Therefore, upon rehearing, the Court should find that the Appellant did not meet the appropriate standard by showing that the proposed reconfiguration of services in January of 2010 placed the Appellant in significant or serious risk of institutionalization.



Richard G. Hepfer
Of Counsel
South Carolina Department of Health
and Human Services
1801 Main Street
P.O. Box 8206
Columbia, South Carolina 29202-8206
Voice: (803) 898-2791
Fax: (803) 255-8210
Bar #3076
Attorney for the Respondent

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

Case No. 2013-000762

Richard Stogsdill ..... Appellant,

v

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

PLAINTIFF'S REPLY TO RESPONDENT'S RESPONSE TO BRIEF OF AMICI CURIAE

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

Attorney for Appellant

RECEIVED
APR 25 2014
SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Case No. 2013-000762

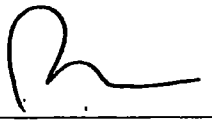
Richard Stogsdill, Appellant,

v

South Carolina Department of Health and Human Services, Respondent.

CERTIFICATE OF SERVICE

Patricia L. Harrison certifies that she has served the *Plaintiff's Reply to Respondent's Response to the Brief of the Amici Curiae* in the above captioned case on the Respondent by United States Mail to the Office of General Counsel, SC Dept of Health and Human Services, PO Box 8206, Columbia, SC 29202-8206 on April 22, 2014. Plaintiff has also served the Amici at their addresses of record by United States Mail.



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

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

Case No. 2013-000762

Richard Stogsdill ..... Appellant,

v

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

PLAINTIFF'S REPLY TO RESPONDENT'S RESPONSE TO BRIEF OF AMICI CURIAE

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

Attorney for Appellant

Table of Contents

1. Introduction. . . . 3

2. More waiver participants were forced into institutional settings after the caps were imposed and the cost of the program increased. . . . 3

3. Individuals are entitled to relief under the Americans with Disabilities Act, regardless of whether the State provides appropriate services to the majority of participants. . . . 4

4. Richard's physician determined that he would be at risk of institutionalization if the services he ordered are not provided. . . . 5

5. Imposition of the caps on services was not necessary for the Agency to operate within its budget and there is no evidence in the record to support the claim that these services were "overutilized." . . . 6

6. The decision to cap services was made without holding public hearings. . . . 8

7. Obtaining CMS approval does not exempt DHHS from complying with the Americans with Disabilities Act and the Medicaid Act. . . . 8

8. The threat of institutionalization is not "speculative." . . . 9

9. This Court may not ignore the decisions of federal courts and the United States Supreme Court in interpreting the Americans with Disabilities Act and the Medicaid Act . . . 9

10. The State has failed to meet its burden of proving that providing the services Richard's physician has ordered would fundamentally alter the State's programs. . . . 12

11. Respondent violated the South Carolina Administrative Procedures Act by establishing a "binding norm" without promulgation of regulations. . . . 13

12. Conclusion. . . . 14

List of Exhibits

1. *T.R. v. South Carolina Department of Corrections* . . . 16

2. *Radaszewski v. Maram*, Case No. 1:01-cv-09554, Entries 172 and 175 (N.D.Ill. 2008) 62

3. *Wilborn v. Martin*, Memorandum Order dated August 15, 2013 . . . 92

4. *Wilborn v. Martin*, Memorandum of Law dated February 18, 2014 . . . 129

5. *Wilborn v. Martin*, Order dated February 18, 2014 . . . 134

Table of Authorities

Federal Cases

Alexander v. Choate, 469 U.S. 287, 105 S.Ct. 712 (1985) 4

Brown v. Board of Education. 347 U.S. 483 (1954). 4

Fisher v. Oklahoma Health Care Auth. 335 F. 3d 1175 (10th Cir. 2003). 12

Fisher v. Oklahoma Health Care Auth., Case No. 4:02-cv-00762,

(Ok.D.C. November 17, 2013). 12

M.R. v. Dreyfus, 663 F.3d 1100 (9th Cir. 2011). 12

M.R. v. Dreyfus, Case No. 2:10-cv-02052-TSZ, Entry 286, (Wash.D.C. Sept. 20, 2013). 12

Olmstead v. L.C., 527 U.S. 581 (1999). ..... Passim

Pashby v. Delia; 709 F.3d 307 (4th Cir. 2013) 12

Radaszewski v. Maram, 383 F.3d 599 (7th Cir. 2004) 10

Federal Statutes

Americans with Disabilities Act ..... *Passim*

Medicaid Act ..... *Passim*

State Cases

Jane Doe v. DHHS, 398 S.C. 62, fn 7 (S.C. 2011). *14*

T.R. v. South Carolina Department of Corrections, Case No. 2005-CP-2925,
Richland County Court of Common Pleas, January 8, 2014. 10

State Statutes

S.C.Code Ann. § 1-23-10(4) (2005) 14

1. Introduction.

Plaintiff requests that the Court accept this Reply to Respondent's Response to the brief filed by Protection and Advocacy for Persons with Disabilities, Inc., South Carolina Legal Services, South Carolina Appleseed Legal Justice Center and the South Carolina Chapter of the National Academy of Elder Law Attorneys.

2. More waiver participants were forced into institutional settings after the caps were imposed and the cost of the program increased.

Respondent states on page 4 of its Response to the Amici Curiae Brief that the State has no interest in "putting more individuals into institutions." But, the documents DHHS filed with CMS demonstrate that before the caps were placed on waiver services in 2010, only 30 persons were forced into ICF/MR facilities to receive respite services, and the average time spent in the facility was 22 days. Record at 893. According to the cost neutrality report in the 2004-2009 MR/RD Medicaid Waiver Document, DHHS paid $157.30 per day for these services, with a total cost for ICF/MR respite services of $103,818. Id. Respondent reported that after the caps were imposed, 126 waiver participants would receive respite services in an ICF/MR facility, spending an average of 33 days in the facility. Record at 893. The total cost of ICF/MR respite services increased more than ten fold, from $103,818 per year, to $1,112,660 per year. Record at 891 and 893. The reimbursement rate for ICF/MR respite services increased from $157.30 per day to $270.00 per day. Id. Appellant agrees with the Respondent that "It is financially and therapeutically better to provide care in the home, in the Waiver." Respondent's Brief at 4. Respondent has failed to rebut the Appellant's arguments that the program cost more to operate after the caps on home-based services were imposed in 2010.

Respondent's claims (these changes were required due to budget reductions are also not supported by the evidence in the record. The total cost of the program in 2009 was $217,252,605, according to the Waiver Document. Record at 891. According to the application DHHS submitted to CMS, the average cost per waiver participant in 2009 was $36,209. Id. According to the letter CMS sent to the director of DHHS on November 9, 2009, the projected annual cost of the MR/RD Medicaid Waiver program beginning in January of 2010 was $278,661,600, an increase in costs of $61,408,995 per year! Record at 75. According to this letter, CMS approved an average cost per participant of $51,869, beginning in January of 2010.[1] Id. Respondent has failed to respond to the claims of Appellant that these figures contradict the agency's claims that the caps were imposed to save money.

3. **Individuals are entitled to relief under the Americans with Disabilities Act, regardless of whether the State provides appropriate services to the majority of participants.**

On page 5, Respondent cites a pre-Olmstead case in support of its argument that all that is necessary is to meet the "general needs of the population" and that only "the needs of the majority of the affected population" should be considered by this Court. *Alexander v. Choate*, 469 U.S. 287, 105 S.Ct. 712 (1985). This would allow Respondent to place 49% of the waiver participants at risk of institutionalization without violating the Americans with Disabilities Act. Under this theory, the State would have met its obligation under the Voting Rights Act by allowing a majority of qualified persons to vote. Or, so long as 51% of black persons are allowed to attend white schools, the State would have met its obligation under *Brown v. Board of*

---

[1] However, DHHS reported on its Cost Neutrality estimates that the average cost per participant would be $44,232.12. Record at 893. This document confirms that the total projected cost of the program after the caps were imposed would be $278,662,353.40 in 2010. Id.

Education. 347 U.S. 483 (1954). This line of reasoning is, of course, absurd. The United States Supreme Court declared in *Olmstead v. L.C.* that segregation of persons who have disabilities is discrimination. 527 U.S. 581 (1999). As decided by the United States Supreme Court in *Olmstead*, the rights of individuals may be enforced under the Americans with Disabilities Act. Id. These rights may be enforced without regard to what services are provided to the other 51% of waiver participants.

4. Richard's physician determined that he would be at risk of institutionalization if the services he ordered are not provided.

Richard's physician, Dr. Thomas C. Joseph, signed a sworn statement stating that Richard requires a minimum of two personal care aides for eight hours a day (total of 16 hours) to assist him with performing functions of daily living. Record at 921 at para. 17 and 20. According to Dr. Joseph, Richard requires an additional five hours a day of adult companion services to replace those services that were formerly provided by the school district and Vocational Rehabilitation. Id. at 18 and 19. Even with these services, Richard's parents would be required to provide 12 hours a day of care during the week and 16 hours a day on weekends. Id. Dr. Joseph determined that Richard needs the respite services contained in his current plan of care. Id. at para. 21. Richard's father has since died and he currently receives additional hours a month of respite, but those services are subject to periodic reevaluation by DHHS. Dr. Joseph's order is supported by facts which are observable and substantiated by medical records and they are based on treating Richard for many years. Dr. Joseph stated that:

> 22. Richard's parents are not able to provide for his care without the supports that have been in place. They are now exhausted from the demands of daily caregiving responsibilities. **Richard would be at risk of institutionalization if the needed home-**

based services are not provided. (Emphasis added.)

Record at 921. Dr. Thomas stated that there would be a "marked decline" in Richard's physical and mental condition" from the trauma of being institutionalized. Record at 921 and 922.

The opinion of Dr. Joseph is supported by the sworn affidavit of Lennie S. Mullis, Richard's DDSN certified provider of psychological services. Record at 917 to 919. Richard himself signed a sworn statement stating that "Without the waiver services I need, I would have to live in an institution." Record at 924. Richard's mother testified: "That would kill Richard" if he were institutionalized." Record at 322. At the time of the hearing, his mother worked six part time jobs "to make ends meet." Record at 309. Respondent's argument that Richard would not be at risk of institutionalization if the caps were imposed on his services is not supported by any evidence in the record. No one in this case has argued that Richard does not need 24/7 care and supervision. His DDSN Service Coordinator reported that he needs "constant hands-on/direct care and supervision." Record at 164. There is nothing in the record to contradict this finding, and, indeed DHHS' witnesses did not even know whether Richard could get out of bed without hands-on assistance. Record at 282.

5. Imposition of the caps on services was not necessary for the Agency to operate within its budget and there is no evidence in the record to support the claim that these services were "overutilized."

On page 6 of Respondent's Brief, the agency argues that these caps should be enforced because it is "essential for state agencies to operate within their budgets." But this argument ignores the fact that the cost of the program actually increased once these caps were put into place, as has been discussed above and in Appellant's Briefs.

Respondent also argues that the caps were imposed because these services were "overutilized." Not only was that "reason" for reducing services not included in any notice provided to waiver participants, there is absolutely no evidence that Richard "overutilized" any waiver service. This "reason" is supported by nothing other than conclusory statements made by Respondent's witnesses Ms. Shealey and Mr. Chorey. The record is devoid of any study or evidence supporting this theory. The Record does contain, however, evidence that DDSN has spent millions of dollars, that the General Assembly intended to be spent providing services, purchasing real estate instead. The audit of DDSN conducted by the South Carolina Legislative Audit Council found that "We estimated that DDSN spent just $7.6 of the $25.4 million appropriated to operate new beds." Record at 720. Out of the $10.5 million of state dollars provided for a new program to serve children with autism, DDSN spent only $671,917 (6%) actually providing the services.[2] When these funds were not used as intended, the LAC reported that the matching 70% of federal funding was lost. Id. Doing the math, this would amount to a loss of more than $50 million in funding that could have been used to provide persons like Richard with services needed to allow them to remain in their homes. The LAC reported:

> We found that DDSN has not yet provided many of the new services for which it received funding. The agency has carried forward, or used for other purposes, the unspent funds. In addition, DDSN has not recouped millions in federal Medicaid dollars it could have received if the services were provided.

---

[2] According to the LAC audit, DDSN carried forward $6.7 million of these funds into FY 09. Record at 724. These funds, when carried forward, "are not designated for specific projects or purposes." Id. This $6.7 million, when matched with federal funds, would have produced more than $20 million available to provide services during the time Richard's initial appeal was pending.

Record at 719.

6. The decision to cap services was made without holding public hearings.

Respondent's claim on page 6 that "public hearings were held throughout the State" is not supported by the record and it ignores the letter sent by the Director of DDSN, Eugene A. "Andy" Laurent. Record at 914. There is no evidence that public hearings were held before the DHHS Medical Care Advisory Committee voted to reduce services. According to the information DDSN's official, Kathi Lacy, provided to the Medical Care Advisory Committee, the decision to cap home-based services was based on responses to an email DDSN sent to 5,700 MR/RD Medicaid waiver participants, to which "about 200" responded. Record at 856. In deciding what services to reduce, Lacy and Waldrep chose those that "have low utilization." Record at 851. The Committee was informed that reductions in funding gave DHHS "a unique opportunity" to "look very critically at the services being offered in the waiver package." Record at 855. The Medical Care Advisory Committed was told that these reductions were necessary "Because of the very tight budget times we face..." But there is no evidence in the record that the Medical Care Advisory Committee was ever informed that the reconfigured MR/RD Medicaid program would cost $60,000 more after the caps were imposed or that the costs and utilization rates for ICF/MR institutional services would increase.

7. Obtaining CMS approval does not exempt DHHS from complying with the Americans with Disabilities Act and the Medicaid Act.

As previously discussed in the briefs of Appellant and the Amici, approval of the reductions by the Atlanta CMS office cannot override the intent of Congress. The authority for enforcement of the Americans with Disabilities Act lies with another agency, the United States

Department of Justice and that agency has interpreted the Act to prohibit reductions such as those involved in this case.

8. The threat of institutionalization is not "speculative."

At page 9 of Respondent's Brief, DHHS argues that the agency "does not believe that the reconfiguration of services ...would force individuals into institutions." Respondent's Brief at 9. But DHHS' own application to CMS documents that the number of persons being forced into ICF/MR facilities to receive respite services would increase more than four fold. Record at 891 and 893. The number of days spent in the institution would increase by 50%.

As discussed above, Richard's risk of institutionalization is not "speculative," it is real. He has provided evidence from qualified medical professionals that he is at risk of hospitalizations and being placed in an institution if the services ordered by his physician are not provided. Record at 920 and 917. Respondent has failed to provide testimony or statements from any witness who has training in medicine to support its claim that Richard could remain in the least restrictive setting if his services were reduced. Respondent's claim that it "does not believe that the reconfiguration of services ..would force individuals into institutions" is simply conclusory and it is not supported by any evidence in the record.

9. This Court may not ignore the decisions of federal courts and the United States Supreme Court in interpreting the Americans with Disabilities Act and the Medicaid Act.

Counsel for Respondent suggests that this Court should ignore the decisions of the Federal Courts because they only maintained the *status quo* through preliminary injunctions. Brief at 11. At oral argument Respondent's counsel advised this Court that his agency believes

that the Federal Courts have gone to far in enforcing *Olmstead.* It is true that many other states have opted to comply with the Americans with Disabilities Act and the Medicaid Act and to provide needed services instead of spending money litigating and continuing to violate the law. South Carolina's choice of fighting to deny needed services instead of spending that money to comply with the law is discussed in Judge Baxley's recent decision in *T.R. v. South Carolina Department of Corrections*, a case involving the State's failure to provide mental health services to inmates. Case No. 2005-CP-2925, Richland County Court of Common Pleas, January 8, 2014. Exhibit 1. In that case, the circuit judge recognized that:

> We are now eight years into this litigation. Rather than accept the obvious at some point and come forward in a meaningful way to try and improve its mental health system, Defendants have fought this case tooth and nail - on the facts, on the law, on the constitutional issues, portraying itself as beleaguered by the burdensomeness of the Plaintiff's discovery, and generally harrumphed by the invasive nature of Plaintiff's counsel's tactics and strategies.
> ...
> The hundreds of thousands of tax dollars spent defending this lawsuit, at trial, and most likely now on appeal, would be better expended to improve the mental health services delivery at SCDC.

Id. at 45.

Respondent points to *Radaszewski v. Maram*, 383 F.3d 599 (7th Cir. 2004) in support of its argument that this Court should not consider federal case law, because DHHS argues that none of those cases have proceeded to trial on the merits. Respondent's Brief at 13. But that case proceeded to trial in 2008 and a judgment was rendered on the merits that was fully favorable to Radaszewski. The Court ordered the State Medicaid Agency to provide 16 hours a day, seven days a week of RN services to Radaszewski, in addition to 336 hours of RN services a year to provide respite for his parents. The district court decisions are attached as Exhibit 2. Case No.

1:01-cv-09554, Entries 172 and 175 (N.D.Ill. 2008).

Respondent also points this Court's attention to a federal district court decision in Tennessee granting a preliminary injunction forcing the State to provide a Medicaid participant with 24-hour home care despite a cost cap on services. *Wilborn v. Martin* (M.D.Tenn., No. 3:13-00574, Aug. 15, 2013). Exhibit 3. Jeremy Wilborn became a quadriplegic after he suffered anoxic brain injury in 2006. Prior to turning age 21, he received 12 hours a day of private duty nursing care, in addition to 12 daily hours of home health aide care under EPSDT (Early and Periodic Screening, Diagnosis and Treatment). When Mr. Wilborn turned 21, the State Medicaid Agency reduced his services to 40 hours per week of home care, despite a physician's order requiring 24-hour-care. Like Richard, Mr. Wilborn lost his state administrative appeals.

In *Wilborn*, the state argued that the cost of providing Mr. Wilborn's treatment at home exceeded the cost of similar services in a nursing home, and therefore Mr. Wilborn could either accept the reduction in home care hours or move into a nursing home. After losing his administrative appeals, Mr. Wilborn filed suit against the state, claiming that it violated his rights under the Americans with Disabilities Act and the Rehabilitation Act. The district court granted Mr. Wilborn's motion for a preliminary injunction, requiring the State to provide care 24 hours a day. According to the federal court docket, the case was settled to Wilborn's satisfaction on February 18, 2014, with an order dismissing his case without prejudice entered on February 19, 2014. Exhibits 4 and 5. The settlement provided that "The parties reached an agreement that satisfies Plaintiff's claims...no less than preliminary injunctive relief." Exhibit 4.

Respondent cites to the dissent of Judge Agee in *Pashby v. Delia,* 709 F.3d 307 (4th Cir. 2013), but the district court in that case granted the plaintiffs' motion for a preliminary

injunction, prohibiting the State from reducing services at issue in the case and that trial is currently expected to begin in early 2015. Entry 164, Case No. 5:11-cv-00273.

Respondent states that no further proceedings were reported after remand by the 10th Circuit in *Fisher v. Oklahoma Health Care Auth.* 335 F. 3d 1175 (10th Cir. 2003). But that case was settled on November 17, 2003. Case No. 4:02-cv-00762.

In *M.R. v. Dreyfus*, the Ninth Circuit Court of Appeals reversed the judgment of the district court and granted injunctive relief with respect to the named plaintiffs, finding that plaintiffs had demonstrated that the State's cuts placed them at serious risk of institutionalization in violation of the ADA. 663 F.3d 1100 (9th Cir. 2011). That case was settled on September 20, 2013 by agreement. Case No. 2:10-cv-02052-TSZ, Entry 286.

10. The State has failed to meet its burden of proving that providing the services Richard's physician has ordered would fundamentally alter the State's programs.

The State simply cannot prevail on the fundamental alteration argument, because it has not met its burden of proving that providing the services Richard's physician has ordered would cause a fundamental alteration in the State's system. Instead, the record contains nothing but the agency's defense of the reductions based on nonexistent "budget reductions" and its reliance on CMS authorization to place caps on waiver services, without regard for the consequences. It cannot rely upon an effective working plan for community integration, because the State has no effectively working *Olmstead* Plan and none is included in the record. In its Response, DHHS references the Statement of the United States Department of Justice on the Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act contained at http://www.ada.gov/olmstead/q&a_olmstead.htm. Response at 10 and 17. That Statement

contains the following requirements for an *Olmstead* plan:

> An *Olmstead* plan is a public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings. A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options or describe the entity's general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities. The plan must have specific and reasonable timeframes and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan, which may come from reallocating existing service dollars. The plan should include commitments for each group of persons who are unnecessarily segregated, such as individuals residing in facilities for individuals with developmental disabilities, psychiatric hospitals, nursing homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs. To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan. A public entity cannot rely on its *Olmstead* plan as part of its defense unless it can prove that its plan comprehensively and effectively addresses the needless segregation of the group at issue in the case. Any plan should be evaluated in light of the length of time that has passed since the Supreme Court's decision in *Olmstead*, including a fact-specific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future.

No fundamental alteration has been demonstrated, because Plaintiff has shown that the caps on services actually resulted in an <u>increase</u> in the costs of the program and that Respondent has failed to rebut those arguments or even to address the costs Plaintiff has submitted at the hearing and in his briefs. At the hearing, Respondent failed to provide any documentation in support of its claims that the caps were necessitated by budget reductions. Record at 263 to 333.

11. Respondent violated the South Carolina Administrative Procedures Act by establishing a "binding norm" without promulgation of regulations.

Respondent ignores clearly established law on the "binding norm" issue, as has been discussed in both Appellant's briefs and the brief of the Amici. Appellant refers the Court to those arguments previously made. Respondent's reliance on *Jane Doe v. DHHS* is misplaced, as

the South Carolina Supreme Court held in that case 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).

398 S.C. 62, fn 7 (S.C. 2011). Because the agency policy at issue in that case had not been formally adopted as a regulation, the Supreme Court held that "it does not have the force and effect of law and is entitled to no deference." Id.

12. Conclusion

In Respondent's Conclusion the agency asks this Court to ignore the interpretation of the Americans with Disabilities Act by the United States Department of Justice. This argument ignores the plain and simple fact that in Sec. 12134 of the Americans with Disabilities Act, Congress charged the Department of Justice with the responsibility for promulgation of regulations to enforce the Act. Instead, Respondent asks this Court to base its decision on what DHHS thinks the federal courts should do in the future, i.e. to give the States the authority to accept federal funds and spend them without regard for Congressional mandates. To be sure, this is not a case about unfunded mandates. According to the DHHS application for the MR/RD Medicaid waiver for 2004-2009 and its 2009 filing with CMS, the agency received $60 million more to operate the MR/RD Medicaid program in 2010 than it had received in 2009.

Richard has provided a sworn statement from his physician confirming his claim that he would be at risk of insitutionalization if this Court does not reverse the decision of the Executive

Branch in this case. This statement is substantiated by a sworn statement of his provider of DDSN psychological services and himself. His mother knows what she is, and is not, able to provide and there is no evidence in the record to suggest that she could provide the care he needs to remain at home if his services were to be reduced. In fact, the evidence in the record shows that she was working six part-time jobs and was exhausted from her caregiving responsibilities, even before Richard's father died. Respondents have provided no evidence from a qualified medical source - or even any testimony from a person familiar with Richard's needs or condition. Richard respectfully requests that this Court reverse the decision of the Administrative Law Court and that it find that providing the services Richard's physician has ordered would not fundamentally alter the State's Medicaid program. He requests that this Court grant the relief requested in his briefs and at oral argument.

Respectfully submitted,



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

April 21, 2014

Exhibit 1. *T.R. v. South Carolina Department of Corrections*

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND T.R., P.R., and K.W., on behalf of themselves and others similarly situated; and Protection and Advocacy for People with Disabilities, Inc., Plaintiffs, v. South Carolina Department of Corrections and William R. Byars, Jr., as Agency Director of the South Carolina Department of Corrections Defendants.	IN THE COURT OF COMMON PLEAS FIFTH JUDICIAL CIRCUIT C/A No.: 2005-CP-40-2925 **ORDER GRANTING JUDGMENT IN FAVOR OF PLAINTIFFS**

2014 JAN -8 PM 12:36
CLERK OF COURT
C.C.P. & G.S.
RICHLAND COUNTY, S.C.
FILED

It has been the privilege of this writer to serve the State of South Carolina as a general jurisdiction judge for fourteen years. At the time this case was heard, Court Administration reported there were more than 5,000 new case filings per year for each of our state's circuit court judges. Thus, over 70,000 cases of every imaginable sort have come to this Court over the years. This case, far above all others, is the most troubling.

This case is a class action brought on behalf of approximately 3.500 state inmates who meet the definition of being seriously mentally ill. For purposes of this suit, the term "serious mental illness" was specifically defined in the Class Certification order dated November 1, 2007, and may be succinctly stated as all SCDC inmates from the date of the filing of the complaint who have been hospitalized for psychiatric services, referred to an Intermediate Mental Health Care Services Unit, or diagnosed by a psychiatrist with the following mental illness: Schizophrenia, Schizoaffective Disorder, Cognitive Disorder, Paranoia, Major Depression, Bipolar Disorder, Psychotic Disorder, or any other mental condition that results in significant

functional impairment including inability to perform activities of daily living, extreme impairment of coping skills, or behaviors that are bizarre and/or dangerous to self or others. Plaintiffs claim that their treatment within SCDC, or lack of treatment, constitutes a violation of the state constitution.

The evidence in this case has proved that inmates have died in the South Carolina Department of Corrections for lack of basic mental health care, and hundreds more remain substantially at risk for serious physical injury, mental decompensation, and profound, permanent mental illness. As a society, and as citizen jurors and judges make decisions that send people to prison, we have the reasonable expectation that those in prison – even though it is prison – will have their basic health needs met by the state that imprisons them. And this includes mental health. The evidence in this case has shown that expectation to be misplaced in many instances.

Economic downturn and financial pressures have brought great change to our country. One of these is that the various state departments of corrections are now more than ever the collection place of the seriously mentally ill among the citizenry. The incidence of serious mental illness within the general population is less than four (4%) percent[1]. In the typical Department of Corrections, it is between 15 and 20 percent. In South Carolina, the evidence in this case shows it to be approximately 17 percent, in spite of the Department's claim that it is 12.9 percent. If 17 percent of the prison population had advanced cancer and there was inadequate and in some cases nonexistent treatment for cancer in prison, the public would be outraged. Yet this is the case for serious mental illness.

[1] Figures vary depending upon the source, demographics, and differences in various definitions of "serious mental illness." The Court takes judicial notice of the statistical findings of the National Institute of Mental Health, which places the general population figure at 3.9%. Further statistical information may be obtained from the NIH at www.nimh.nih.gov/statistics/SMI_AASR.shtml.

This litigation does not occur in a vacuum. What happens at the Department of Corrections impacts all of us, whether it is from the discharge of untreated seriously mentally ill individuals from prison into the general population, or tremendously increased costs for treatment and care that might have been prevented, or the needless increase in human suffering when use of force replaces medical care. The decisions of our Courts reflect the values of our society. To that end, our state can no longer tolerate a mental health system at the South Carolina Department of Corrections that has broken down due to lack of finances and focus.

While the Court finds the inadequacy of the mental health system at SCDC has not occurred by design, but instead by default, the Court further finds this decision in favor of Plaintiffs should not come as a shock to SCDC. Previous internal and external reviews of the SCDC mental health system have found multiple inadequacies and failures. Despite its knowledge of the grave risks these deficiencies pose to mentally ill inmates, SCDC has failed through the years to take reasonable steps to abate those risks. The Court recognizes that the Department is underfunded and understaffed in many particulars, not just mental health services delivery. The operation of any state agency is a matter of competing priorities, and the General Assembly, as keeper of the public purse, is not in a position to excessively fund any entity. Thus, this decision will ultimately require an increase in priority for mental health services commensurate with the level of serious mental illness within the prison population.

DECISION

In its prior Order Setting Forth Applicable Constitutional Standards ("Standards Order"), the Court delineated the standard of liability and burden of proof applicable to Plaintiffs' constitutional claim under Article I, § 15 of the South Carolina Constitution, which prohibits "cruel and unusual punishment." To prevail on a claim under Article I, § 15, the Court stated

that Plaintiffs must prove that Defendants acted with "deliberate indifference to serious medical needs of prisoners." Standards Order at 3 (quoting *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). This deliberate indifference standard contains both an objective and subjective component. *See Farmer v. Brennan*, 511 U.S. 825, 834-37 (1994). To satisfy the objective component, Plaintiffs must demonstrate that they are subjected to a substantial risk of harm that is sufficiently serious. *Id.* The objective component is not limited to past harm, but also protects inmates from an unreasonable risk of future harm. *Helling v McKinney*, 509 U.S. 25, 35 (1993). Plaintiffs may satisfy the objective component by showing that systemic deficiencies in a prison mental health system expose inmates with serious mental illness to a substantial risk of serious future harm. Standards Order at 7-8, *citing Helling*; 509 U.S. at 35; *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983); *Flynn v. Doyle*, 2009 WL 4262746 at *19 (E.D. Wis. 2009); *Madrid v. Gomez*, 889 F. Supp. 1146, 1256 (N.D. Cal. 1995); *Neiberger v. Hawkins*, 208 F.R.D. 301, 317 (D. Colo. 2002).

The Court noted the need for guideposts in determining whether Plaintiffs satisfied the objective component of the deliberate indifference standard. Accordingly, within this legal framework, the Court identified and articulated six factors that would serve as benchmarks for determining whether SCDC's mental health program exposed mentally ill inmates to a substantial risk of serious harm. Stated succinctly, the evidence at trial should establish whether the SCDC mental health services system contained the following adequately functional components:

1. A systematic program for screening and evaluating inmates to identify those in need of mental health care;

2. A treatment program that involves more than segregation and close supervision of mentally ill inmates;

3. Employment of a sufficient number of trained mental health professionals;

4. Maintenance of accurate, complete, and confidential mental health treatment records;

5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation; and

6. A basic program to identify, treat, and supervise inmates at risk for suicide.

Standards Order at 8-10, *citing Ruiz v. Estelle,* 503 F. Supp. 1265, 1339 (S.C. Tex. 1980) *aff'd in part, rev'd in part,* 679 F.2d 1115 (5th Cir. 1982), *amended in part, vacated in part,* 688 F.2d 266 (5th Cir. 1982), *cert. denied,* 460 U.S. 1042 (1983).

Employing these factors in the context of the objective component of the deliberate indifference standard, the Court finds by a preponderance of the evidence that the Plaintiffs have met the burden of proof and makes the following threshold findings.

First, the mental health program at SCDC is severely understaffed, particularly with respect to mental health professionals, to such a degree as to impede the proper administration of mental health services. This deficiency has a substantial impact on every aspect of the mental health program, beginning at Reception and Evaluation ("R&E"), where inmates are screened and evaluated for mental health needs, continuing into the treatment programs for seriously mentally ill inmates, and ending with deficient discharge planning for seriously mentally ill inmates being returned to the general public.

Second, seriously mentally ill inmates are exposed to a disproportionate use of force and segregation (solitary confinement) when compared with non-mentally ill inmates. Segregation and use of force are often used in lieu of treatment, with severe consequences for inmates with

serious mental illness. The inappropriate and extended reliance on segregation to manage inmates with serious mental illness, particularly those in crisis, exposes them to a substantial risk of serious harm by limiting their access to mental health counselors and psychiatrists, disturbing their eating and sleeping cycles, disrupting the administration of medications, and deepening their mental illnesses. These conditions have contributed to the deaths of multiple inmates in segregation, while placing other inmates and staff at risk. They have also led to the stigmatization of mental illness within SCDC that discourages inmates from seeking the limited mental health care the agency does provide.

Third, mental health services at SCDC lack a sufficiently systematic program that maintains accurate and complete treatment records to chart overall treatment, progress, or regression of inmates with serious mental illness.

Fourth, SCDC's screening and evaluation process is ineffective in identifying inmates with serious mental illness and in providing those it does identify with timely treatment.

Fifth, SCDC's administration of psychotropic medications is inadequately supervised and evaluated.

Sixth, SCDC's current policies and practices concerning suicide prevention and crisis intervention[2] are inadequate and have resulted in the unnecessary loss of life among seriously mentally ill inmates.

As a result of the above findings, the Court further finds that SCDC's mental health system exposes seriously mentally ill inmates to a substantial risk of serious harm and Plaintiffs have therefore satisfied the objective component of the deliberate indifference standard.

[2] "Crisis intervention" refers to SCDC's response to an actively mentally ill inmate who poses an immediate danger and must be sequestered for his own protection or the protection of other inmates and correctional officers.

The subjective component is met by proof that a defendant "knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *Farmer*, 511 U.S. at 834-837. At trial, the Plaintiffs presented overwhelming evidence that SCDC has known for years that its policies and practices expose seriously mentally ill inmates to a substantial risk of serious harm but has failed to take reasonable measures to abate that risk. The Court finds, therefore, that the Plaintiffs have satisfied the subjective component of the deliberate indifference standard.

As a result of the above findings, the Court grants judgment in favor of the Plaintiffs.

Below, the Court has separated the remainder of this Final Order into two sections. The first section articulates the factual findings and conclusions underlying the Court's decision with respect to the objective component by examining each of the six *Ruiz* factors listed above. The first section then articulates the factual findings and conclusions related to the subjective component. The findings made therein are by a preponderance of the evidence. Section Two then addresses the remedy the Court will grant in this case and the mechanism used to achieve it.

With regard to the factual findings and conclusions mentioned below in Section One, there are several references to individual circumstances involving specific inmates. The Department argued at trial that reference to an individual inmate and his/her particular situation was anecdotal and not indicative of the general administration of mental health services. Moreover, counsel for SCDC essentially argued that some of the specific inmate situations were "outliers" in that such was a constellation of unique events and circumstances that brought about an unfortunate result. The Court specifically rejects that argument. While no system involving thousands of inmates is expected to be perfect, the Court finds that the individual circumstances

referred to below are the result of a system that is inherently flawed in many respects, understaffed, underfunded, and inadequate.

I. FACTUAL FINDINGS/DISCUSSION

A. Objective Component

1. A systematic program for screening and evaluating inmates to identify those in need of medical care

As of 2011, 12-13 percent of the SCDC inmate population had been diagnosed by SCDC with a mental illness and was on the Department's mental health caseload. From that data, with a total inmate population at the time of trial of 23,306, a 12.9 percent fraction yields an approximate figure of 3,006 inmates that have been diagnosed as mentally ill.[3] Based on universally accepted national statistics, evidence presented to the Court at trial strongly indicates this percentage should be much higher. Multiple studies conducted nationwide suggest that a more accurate percentage of inmates with a serious mental illness should be somewhere in the range of 15 to 20 percent. SCDC's expert, Dr. Scott Haas, testified that seriously mentally ill inmates ordinarily comprise 18 percent of a prison population. Plaintiffs' expert, Dr. Raymond F. Patterson, testified that after detailed analysis, 17 percent was a conservative estimate of SCDC's seriously mentally ill population, and the Court finds the basis of his analysis to be credible.

The Court further finds this low, acknowledged percentage of mentally ill inmates at SCDC troubling because it indicates a high likelihood that there are hundreds of inmates with a serious mental illness at SCDC who are not receiving any treatment due to deficiencies in the screening and evaluation process used to identify and classify those with a serious mental illness.

[3] Exact numbers fluctuate due to the constant intake and release of inmates.

This low identification of mentally ill inmates has a synergistic impact on the mentally ill population, as it leads to a reduction in mental health professionals, the further disproportionate cutting of costs in difficult economic times within the mental health system because of a perceived lack of need for services, and a skewed analysis as to the efficacy of the existing mental health system. R&E serves as the intake facility for inmates entering into SCDC. If inmates with mental illnesses are not identified and appropriately classified at R&E, the Court finds that these inmates face a substantial risk of serious harm.

In addition to the concerns mentioned above, there was also evidence presented to the Court of regular violations of the SCDC mental health policy, two of which are particularly relevant to the Court as they relate to the screening and evaluation process at R&E. First, SCDC policy requires that a mental health counselor must meet with an inmate within 48 hours of the inmate being assigned to that counselor's caseload. At trial, there was evidence submitted to the Court of regular and persistent violations of this policy. Second, inmates are not being seen by a psychiatrist within thirty days of the counselor's initial assessment when a need for psychiatric treatment is indicated, also a violation of SCDC policy. Consequently, this results in inmates who are referred to a psychiatrist at R&E, but are then transferred into SCDC general population prior to assessment by that psychiatrist, creating a risk of harm for all inmates.

The Court finds, due to the concerns listed above, that the program used by SCDC for screening and evaluation fails to adequately identify and classify those inmates suffering from serious mental illness, thereby exposing them to a substantial risk of serious harm.

2. **A treatment program that involves more than segregation and close supervision of mentally ill inmates**

a. **Segregation**

The treatment program at SCDC places heavy reliance on segregation and use of physical force against seriously mentally ill inmates, as opposed to treatment.

Mentally ill inmates are substantially overrepresented in segregation units, known as Special Management Units ("SMU"), within SCDC. Inmates in segregation stay in solitary confinement in their cells 23-24 hours a day. Visitation, telephone, and other privileges are significantly restricted. As of September 2011, the percentage of mentally ill inmates in SMUs at the three SCDC institutions where the majority of men with serious mental illness are assigned ("Area Mental Health Institutions") demonstrates the disproportionate use of segregation to which members of the Plaintiff class are subjected. At Lee Correctional Institution ("Lee"), 16 percent of the total inmate population was mentally ill, yet 27 percent of its inmates in SMU were mentally ill.[4] The corresponding numbers at Perry Correctional Institution ("Perry") were 24 percent and 40 percent. At Lieber Correctional Institution ("Lieber"), the differential was even greater, where mentally ill inmates comprised 20 percent of all inmates, yet 42 percent of the inmates that were in segregation. During this same period, the percentage of mentally ill inmates in SMUs in all SCDC institutions was 23 percent, even though they represented less than 13 percent of the total inmate population.

Taking the entire population into consideration, a mentally ill inmate is twice as likely to be placed in segregation as a non-mentally ill inmate. As of September 2011, 16 percent of inmates on the mental health caseload were in SMUs in contrast with 8 percent of non-mentally ill inmates. For security detention, the most restrictive form of segregation, where inmates are placed in solitary confinement for indefinite periods, mentally ill inmates are more than three

[4] These percentages are based on the SCDC mental health caseload.

times more likely to be assigned this status than other inmates, at a rate of 8.7 percent compared with 2.8 percent.[5]

Not only are mentally ill inmates overrepresented in SMUs, they also spend disproportionately longer periods of time in the SMUs. For many mentally ill inmates, this period of isolation in SMU has lasted for several years. For example, the average cumulative disciplinary detention sentence for inmates with mental illness as of January 13, 2012 was 647 days, compared to 383 days for non-mentally ill inmates. These averages include extremely long periods of segregation for inmates whose disciplinary detention sentences exceeded their projected release date from SCDC. Again, these extended sentences were meted out against mentally ill inmates at over twice the rate of other inmates. The lengths of these sentences in segregation were also far greater for members of the Plaintiff class, exceeding their projected release date on average by 1,968 days or 5.39 years, compared with 1,065 days or 2.92 years for other inmates. Of the ten longest periods of disciplinary detention sentences beyond projected release dates, nine of the inmates were mentally ill. Their cumulative sentences for solitary confinement ranged from 20-36 years.

The evidence showed that these extended periods of segregation too often reflect the accumulation of disciplinary detention sentences for non-assaultive behavior of mentally ill inmates. For example, one 51-year-old mentally ill inmate who had been hospitalized at SCDC's psychiatric facility accumulated 19 years of disciplinary detention sentences from 2005-2008. For one non-assaultive offense in which he threatened harm, he received 999 days of disciplinary detention and lost visitation for three years. In interviews with Plaintiffs' experts, he was

[5] The two principal forms of punitive segregation are security detention and disciplinary detention. Disciplinary detention consists of sentences served in segregation for a specific period of time for violation of SCDC administrative rules. Security detention is a classification assigned to inmates determined to present a particular risk to other inmates or staff that often remains in effect for periods lasting several years.

distressed that he was being denied "400 million dollars in his bank" and was set to appear on the television program "The Rich and Famous."

A 27-year-old female mentally ill inmate accumulated six and a half years of disciplinary detention segregation and lost access to the telephone and visitation for eight years for non-assaultive offenses, most of which were verbal or profane threats to staff or other inmates. One of the charges was prompted when she threatened two inmates who were making derogatory remarks about a medical condition that required her to wear diapers.

The evidence revealed that the great majority of the extreme periods in segregation are in fact served. For example, Leslie Cox, a member of the Plaintiff class, was confined in SMU for at least 2,565 consecutive days, from February 2001 - February 2008. James Wilson, another mentally ill inmate, was confined in SMU for at least 2,491 consecutive days.[6] SCDC records provide conflicting information about mentally ill inmate Rowland Dowling, who spent either 1,777 or 2,200 consecutive days in solitary. Other mentally ill inmates were confined in solitary for similarly lengthy periods.

SCDC's Guilty But Not Accountable ("GBNA") policy should theoretically reduce the number of mentally ill inmates in segregation but, in fact, has had a negligible effect. SCDC counselors are responsible for recommending findings of GBNA but this Court finds that, as Dr. Patterson testified, many SCDC counselors are not qualified to analyze accountability. Only 2 percent of mentally ill inmates receiving segregation sentences are determined to meet GBNA criteria.[7] Moreover, of those found to be GBNA, the finding has had no effect on their

[6] SCDC records indicate that inmates Cox and Wilson were still in segregation as of February 25, 2008. It is unknown how much longer they remained in segregation after that date.

[7] Evidence introduced by Plaintiffs also showed that a small percentage of the disciplinary detention sentences for male mentally ill inmates at Area Mental Health Institutions were reduced or waived during a 21-month review period between 2010 and 2011.

sentences. Of all inmates in SCDC custody on September 1, 2011 who had been found GBNA, 25 were mentally ill. Despite being found "not accountable," all 25 had been sentenced to segregation.

The American Correctional Association ("ACA") defines disciplinary detention or punitive segregation as follows:

> A form of separation from the general population in which inmates committing serious violations of conduct regulations are confined by the disciplinary committee or other authorized group for ***short periods of time*** to individual cells separated from the general population.

ACA *Standards for Adult Correctional Institutions Supplement*, p. 306 (2008) (emphasis added).

The ACA standards also recognize the potentially harmful effects of punitive segregation on the mental health of any inmate:

> Inmates whose movements are restricted in segregation units may develop symptoms of acute anxiety or other mental health problems; regular psychological assessment is necessary to ensure the mental health of any inmate confined in such a unit beyond 30 days.

ACA *Standards for Adult Correctional Institutions*, 3rd Edition, Standard 3-4244 (2008).

The evidence presented by Plaintiffs demonstrates that SCDC consistently showed little to no regard for the mental health of inmates in imposing periods of disciplinary or security detention, in the lengths of the segregation imposed, or in the effects on mentally ill inmates. The Department's practice consistently violates the ACA standards. Neither the disciplinary detention sentences nor classifications in security detention are for short periods of time. Once in segregation, the level of therapeutic care or intervention to address the needs of mentally ill inmates is grossly inadequate.

Dr. Janet Woolery, the principal psychiatrist at Lee, estimated that approximately 40-50 percent of the Lee SMU inmates she saw were demonstrating active psychotic symptoms.

Rather than placing mentally ill inmates into treatment programs, it appears that they are merely placed in SMUs. SMU patients receive no group therapy and sessions with both psychiatrists and mental health counselors are seldom held in a confidential setting. Sixty-three percent of the counselor audits produced by SCDC noted deficiencies for untimely psychiatric sessions and 77 percent noted deficiencies for untimely counselor assessments. Patient medical records provide further evidence that SMU patients often do not see psychiatrists or counselors on a timely basis. For example, SCDC policy requires that Edward Barton, diagnosed with schizophrenia and classified as an Area Mental Health patient, be seen by a mental health counselor at least once every 30 days, as well as by a psychiatrist at least once every 90 days. Yet, from July 2008 – November 2010, while confined in an SMU, Barton on six occasions went over 30 days without seeing a counselor; on four of those occasions he went over 60 days without seeing a counselor; and once he went 9 months without seeing a counselor. From September 2010 – August 2011, Barton twice went over 120 days without seeing a psychiatrist and once went over 6 months.

SCDC's heavy reliance on segregation of mentally ill inmates raises serious concerns for the Court. As acknowledged by SCDC Mental Health Regional Coordinator Jacqueline Strong, risk factors for psychosis and suicide increase while an inmate is in SMU. It is not uncommon for an inmate in SMU to develop depression and experience a disturbance in eating and sleeping cycles.[8]

[8] Defendants relied upon a Colorado Department of Corrections study to assert that long-term segregation has no significant detrimental effect on mental health. However, the Court finds that the Colorado study is distinguishable from the situation at SCDC for two reasons. First, the Colorado study was limited to inmates who had spent no more than twelve consecutive months in segregation. Many SCDC mentally ill inmates stay in segregation for much longer periods of time. Second, the Colorado study was expressly limited to SMUs with substantially similar conditions to the Colorado State Penitentiary. Plaintiffs' two psychiatric experts, Dr. Metzner and Dr. Patterson, each testified they were familiar with the Colorado State Penitentiary and that conditions in SCDC segregation units were much harsher. As Dr. Patterson testified, the difference was like "night and day."

Moreover, evidence in the case shows conditions in SMUs fall below what is acceptable for a 21st century correctional institution. SMU cells are both extremely cold and inordinately filthy, often with the blood and feces of previous occupants smeared on the floor and walls.

Within the SMU of Lee Correctional Institution is a special 8-cell unit known as "Lee Supermax." On February 7, 2008, inmate Jerome Laudman was transferred to a cell in Lee Supermax. Laudman was schizophrenic, intellectually disabled, and had a speech impediment. According to his mental health counselor, he was neither aggressive nor threatening. No one notified the counselor of Laudman's transfer to Lee Supermax. According to an internal SCDC investigative report, Laudman was sprayed with chemical munitions and physically abused by a correctional officer during the transfer to Lee Supermax. The move was videotaped pursuant to policy, but when viewed by the SCDC investigator, the tape was, inexplicably, mostly blank. Laudman was stripped naked and left in a completely empty Supermax cell.

On February 11, a correctional officer observed that Laudman was sick and weak but did not report it. At some point after February 11, Laudman stopped eating and taking medication. On the morning of February 18, a correctional officer saw Laudman lying on the cell floor in feces and vomit. He lay there "all morning," according to the SCDC investigative report. At approximately 1:30 or 2:00 p.m., two nurses were called. They reported that, in addition to feces and vomit, 15-20 trays of rotting, molding food were in the cell. Both the nurses and the correctional officers refused to retrieve the body. After a further delay, two inmates came to retrieve Laudman, who was unconscious but alive. Later that afternoon, however, he died in a local hospital ER of a heart attack. The hospital report noted the presence of hypothermia. The SCDC investigator found evidence of an attempted cover-up by correctional officers who cleaned Laudman's cell before photographs could be taken. Even after the cleaning, the

photographs taken by the investigator show the cell in a deplorably dirty state. After Laudman's death, SCDC did no quality improvement reviews of Lee Supermax procedures and practices. In September 2008, seven months after Laudman's death, Dr. Metzner and Dr. Patterson inspected Lee Supermax and described it as "filthy."

b. Use of force

Mentally ill inmates also suffer from disproportionate, unnecessary, and excessive uses of force.

i. Disproportionate Use of Force. Between January 2008 and September 2011, mentally ill inmates were subjected to uses of force at a rate two and half times greater than non-mentally ill inmates. During this period, 27 percent of the Plaintiff class was subjected to the use of force in contrast to only 11 percent of other inmates. At the Area Mental Health Institutions for men, the reliance on use of force was even greater. At Lee, Lieber, and Perry, 40 percent, 43 percent, and 44 percent of mentally ill inmates were subjected to force, respectively, while the corresponding numbers of non-mentally ill inmates subjected to force at these institutions were 23 percent, 21 percent, and 16 percent, respectively. Although force was applied far less frequently at Camille G. Graham Correctional Institution ("Graham"), the Area Mental Health Institution for women, the same pattern was present. During the relevant review period, only fourteen use-of-force incidents were reported; however, ten of these incidents were directed toward mentally ill women, even though members of the Plaintiff class constituted less than half of the total inmates at Graham.

The evidence was clear and compelling that SCDC resorts to use of force in the agency's attempt to manage the conduct of mentally ill inmates. Of the inmates who were subjected to use of force, each mentally ill inmate who had been the object of a reported use of force during this

period was subjected on average to 3.35 separate incidents, while the use-of-force rate for other inmates was almost half that, at 1.72 incidents per inmate.

Of the thirty inmates most frequently subjected to the use of force, twenty-six were on the mental health caseload. The mental health conditions were so serious for many of these individuals that fifteen of the twenty-six required hospitalization during the same period at Gilliam Psychiatric Hospital ("Gilliam" or "GPH"). Ten of these fifteen inmates were hospitalized on multiple occasions. James Howard was subjected to 81 separate use-of-force incidents. Mr. Howard was hospitalized for psychiatric treatment on five separate occasions during this same period between January 2008 and September 2011.

SCDC's overreliance on the use of force in attempting to manage mentally ill inmates is, in part, a direct effect of the lack of training correctional officers receive. SCDC training coordinator Yolanda Delgado testified in deposition only twelve days before trial that "less than a handful" of correctional officers attended training sessions intended to improve the staff's knowledge and skills in dealing with mentally ill inmates.

ii. Unnecessary and Excessive Use of Force. Plaintiffs' corrections expert, Steve J. Martin, testified that while SCDC's use-of-force policy was consistent with national correctional standards, its use-of-force practices were not. Based on his review of over 1,000 incident reports at SCDC involving OC spray (pepper spray), Mr. Martin testified a pattern and practice existed that violated national standards and SCDC's own use-of-force policy. First, Mr. Martin testified in detail about eighteen case examples at SCDC of the unnecessary use of force where no threat of harm or other urgent circumstances were present and, in some cases, where OC spray was used simply as punishment. Mr. Martin testified, and the Court finds, that these cases were representative of the more than 1,000 incidents he

reviewed. Second, Mr. Martin found it common for SCDC correctional officers to use excessive force. For example, contrary to SCDC policy, SCDC officers routinely gas inmates with OC spray in amounts that exceed manufacturer instructions and at closer distances than the manufacturer directs. Mr. Martin identified nine case examples, documented in SCDC reports, where SCDC officers had used MK-9 crowd control fogger devices in large disbursements in individual closed cells, again contrary to manufacturer instructions and SCDC policy. In fact, Mr. Martin testified that having reviewed thousands of uses of OC spray in prisons and jails throughout the country, he had "never seen MK-9, a crowd control contaminant, so frequently used by a correctional force inappropriately." The use of such force is without penalogical justification.

SCDC's unnecessary and excessive use of OC spray on mentally ill inmates is consistent with its unnecessary and excessive use of physical restraints. Contrary to its policy and national correctional standards, SCDC places inmates in restraint chairs for predetermined blocks of time in set, four-hour increments.[9] For example, on December 12, 2007, inmate Steven Patterson was transferred to Perry from Gilliam but, by SCDC's mistake, with only five days' worth of psychotropic medications. On January 2, 2008, Patterson's medical record noted that he had not received medication since December 17, 2007 "and he's not doing well." That same day, he cut himself with a plastic spoon and was placed naked in a restraint chair for twelve hours, even though the videotape of his time in the chair shows him calm and cooperative. On January 3, he was returned to Gilliam.

[9] SCDC witnesses testified this practice was changed shortly before the start of this trial so that inmates no longer will be placed in restraint chairs for predetermined blocks of time. The timing of this change concerns the Court, however, for "practices may be reinstated as swiftly as they were suspended." *Thomas v. Bryant*, 614 F.3d 1288, 1320 (11th Cir. 2010).

Mr. Patterson's experience was only one example of how SCDC uses restraint chairs as a substitute for medical treatment. Plaintiffs entered into evidence two gruesome SCDC videotapes of inmates with self-inflicted wounds who were kept in the restraint chair for extended periods of time before receiving adequate medical treatment. Inmate Jerod Cook cut himself on his arm. Approximately 90 minutes after being discovered, he was placed in a restraint chair where he remained for four hours. The videotape shows a pool of blood on the floor of Mr. Cook's cell. He is hardly able to stand before being placed in the restraint chair. He continues to bleed while in the restraint chair and pleads with correctional officers for medical help. As Dr. Patterson testified, the decision by security staff – rather than by medical staff – to keep Mr. Cook in a restraint chair for four hours under those conditions was an "outrageous, horrific response."

Inmate Baxter Vinson underwent a similar experience, cutting himself in the abdomen while in his cell. Approximately three hours and twenty minutes after his wound was discovered, security staff placed him in a restraint chair where he remained for approximately two hours before being transported to a hospital. The videotape shows that while in the restraint chair, Mr. Vinson is eviscerating, with his intestine coming out of the abdominal wall. The tape shows correctional officers tightening the restraints, thereby putting additional pressure on his abdomen. As Dr. Patterson testified, this was a medical emergency that required a sterile environment. The videotape gives further evidence of what Dr. Patterson characterized as "a broken system."

Inmates are often placed naked in restraint chairs. Bathroom breaks are infrequent, so that at times they are forced to urinate in the chair. A common practice at Perry when placing inmates in a restraint chair is to secure them in a painful, "crucifix" position, demonstrated to

Mr. Martin both by Perry correctional officers and inmates. Inmates Richard Patterson and Jonathan Roe both testified about spending hours in what they characterized as the "Jesus" position.

OC spray and restraint chairs are not the only methods of physical force employed by SCDC against mentally ill inmates. Shawn Wiles, a mentally ill inmate in SCDC's Maximum Security Unit, testified that correctional officers restrained his arms in a twisted position, soaked him with water, and left him outside for approximately an hour on a cold December night.

While SCDC contends these are isolated examples of inappropriate conduct by correctional officers, it offered little or no evidence of effective supervisory oversight of the use of force. Mr. Martin testified that one of the standard protections prison systems use to guard against excessive use of force is review of use-of-force incidents. The first element of an effective review process is an examination of the cases that are referred to senior management for review of questionable uses of force. The second element consists of an assessment of the findings concerning allegations of inappropriate force and corrective actions taken. Of the more than one thousand cases Mr. Martin reviewed, very few were referred to senior SCDC officials to assess an alleged inappropriate use of force. Mr. Martin found that of the few cases that were referred, SCDC officials made virtually no findings of excessive or unnecessary force.

In a prison system of more than 23,000 inmates, Mr. Martin testified that the almost complete absence of the identification by managers of inappropriate uses of force is a "huge red flag" that raises serious questions about the existence of an effective system to manage the use of force by correctional officers. Mr. Martin testified that the risk of harm to mentally ill inmates from the unnecessary and excessive use of force, if left unattended and not corrected, is ongoing

and substantial. The Court finds Mr. Martin's testimony, and the bases for his opinions, to be credible.

The Court is concerned by the absence of referrals for investigation of the cases presented by Mr. Martin, and the absence of findings by senior SCDC managers that those cases raise serious questions about the application of force against mentally ill inmates. The Court finds that such excessive uses of force have been largely unreported, uninvestigated, and unmanaged. The Court further finds that Plaintiffs have proven a pattern and practice of the use of unnecessary and excessive force.

c. Limited involvement of psychiatrists

A substantial contributing factor to the lack of an effective treatment program is the limited involvement of psychiatrists in creating and administering treatment plans for mentally ill inmates. Psychiatrists at SCDC have no administrative or policy-making duties, and there is evidence that they do not attend meetings to create and develop treatment plans for inmates. The Court finds that psychiatrists, as the lead mental health professionals in the mental health program, must be more directly involved in creating and developing treatment plans. Furthermore, deposition testimony of some psychiatrists reveals an alarming lack of knowledge of policies and procedures at SCDC, the levels of care and criteria for referral to a particular level of care, and the role of the counselor in the mental illness treatment process. For example, SCDC psychiatrist Dr. Poiletman did not know what the terms SMU and CI stood for – meaning Special Management Unit and Crisis Intervention – terms inextricably tied to mentally ill inmates at SCDC. He did not know the difference between Area Mental Health patients and outpatients, did not know what mental health counselors do, and had "no idea" who drafted treatment plans. Likewise, Dr. Crawford, the principal psychiatrist at Graham, could not

describe the distinction between an Intermediate Care Services patient and an Area Mental Health Patient. She did not review treatment plans and did not start attending treatment team meetings until after her deposition. Dr. Woolery, the principal psychiatrist at Lee, was unfamiliar with treatment plans, did not know whether any of her patients were in Lee Supermax, and had never seen Lee Supermax herself. The Court finds these examples both illuminating and disturbing. For psychiatrists and other mental health staff at SCDC to provide effective services, they must have a more intimate knowledge of the processes and procedures vital to the mental health services system they are expected to direct.

d. Limited access to higher levels of care

Finally, SCDC's treatment program fails to provide mentally ill inmates with sufficient access to higher levels of care. All correctional mental health systems are organized by levels of care, and SCDC's system comprises four levels. From lowest to highest, these are outpatient, area, intermediate (ICS), and inpatient. The higher the level, the more services and staffing are required.

SCDC's Mental Health Director, Pamela Whitley, estimated that in 2008 the combined ICS and Area Mental Health caseload at SCDC was 515. In 2012, however, the combined ICS and area caseload was only 310, a 40 percent reduction. In February 2008, at Lee and Lieber combined there were 212 area and 211 outpatient mental health inmates, a 50/50 split. By September 2011, however, there were only 83 area inmates at Lee and Lieber (14.8 percent), while the outpatients numbered 478 (85.2 percent). From 2003 to 2011, male ICS inmates decreased from 315 to 135. The women's ICS program was discontinued, then revived, but at the time of trial consisted of only five inmates. In the 1990s Gilliam, the 88-bed inpatient psychiatric facility for male inmates, operated at full capacity, but at the time of trial only 47

beds were filled. It is undisputed that women inmates have a higher rate of mental illness than male inmates, but from 2007-2009 SCDC referred only 13 women to Geo Care (formerly "Just Care"), a private company with which SCDC contracts for inpatient psychiatric services for female inmates. SCDC offered no persuasive explanation for the decline in the number of inmates receiving higher levels of services during a period when the overall inmate population and mental health case load remained flat.

e. Conclusion

This Court finds that SCDC's use of force and segregation, as opposed to treatment, in a mental health system where psychiatrists have limited roles and where inmates face systemic obstacles in accessing higher levels of care, creates a substantial risk of serious harm for inmates with serious mental illness.

3. Employment of a sufficient number of trained mental health professionals

The Court finds that the mental health program at SCDC is substantially understaffed. This has a causal effect for many insufficient aspects of the mental health program and greatly inhibits SCDC's ability to provide effective services to its mentally ill inmate population.

From 2008-2011, psychiatric staff at SCDC (psychiatrists and psychiatric nurse practitioners) ranged from 4.5 to 5.5 full-time equivalents (FTEs). At the time of this trial, SCDC had 5.5 FTE psychiatric staff serving an estimated 2,409 inmates on psychotropic medication, for a ratio of 1:437. If 17 percent of SCDC's population is mentally ill, rather than the 12.9 percent diagnosed by SCDC, the estimated number of inmates on psychotropic medication should be 3,170 and the ratio then is 1:575. Based on the testimony of Dr. Metzner and Dr. Patterson, the Court finds an appropriate ratio would be one FTE psychiatrist/psychiatric

nurse practitioner to every 150-200 inmates on psychotropic medication. At Gilliam, there are 1.2 FTE psychiatrists and psychiatric nurse practitioners for 62 patients, a 1:52 ratio. Based on the testimony of Plaintiffs' experts, the Court finds that an appropriate ratio for an inpatient setting would be 1:20. For the ICS program, there is currently .7 FTE psychiatric staff for 135 patients, a ratio of 1:193. Based on the testimony of Plaintiffs' experts, the Court finds that an appropriate ratio for intermediate care would be 1:150.

The Court also finds that SCDC is understaffed in clinical psychologists. In 2003, SCDC employed or retained four FTE clinical psychologists but needed, by its own admission, seven. From 2007-2011, however, SCDC averaged only .3 FTE psychologists.[10] To add some context, SCDC's expert, Dr. Haas, testified that the Kentucky Department of Corrections, his former employer, had 15-16 FTE psychologists to serve a total population of 12,000 – 13,000 inmates, a ratio of approximately 1:800. By contrast, SCDC's .3 FTE psychologists serve a total population of approximately 23,000 inmates, a ratio of 1:69,697.

Likewise, the ratio for counselors at Area Mental Health Institutions as of January 2012 is also problematic: 1:72 at Lee; 1:84 at Perry, and 1:100 at Lieber. In response to this information, Dr. Patterson and Ms. Whitley, SCDC's Mental Health Director, agreed that a more appropriate ratio for counselors at the Area Mental Health Institutions is 1:40. Counselor staffing at outpatient prisons is also insufficient. Ms. Whitley testified she became "very concerned" when counselor-patient ratios at outpatient prisons exceeded 1:65, and Dr. Patterson agreed. SCDC data, however, shows that counselor ratios at most of its outpatient prisons exceed 1:65. At the time of trial, the counselor-patient ratio at McCormick Correctional Institution was 1:157 and at Turbeville Correctional Institution 1:183.

[10] Shortly before trial, SCDC increased its psychologists to .7 FTE.

In total, Dr. Patterson recommended that SCDC employ at least an additional 20 FTE counselors, 14.5 FTE psychiatrists, and 17 FTE other types of mental health professionals. The Court accords great weight to Dr. Patterson's recommendations for staffing.

While it is clear that SCDC does not have enough counselors, it is equally clear that many of the counselors they do employ are unqualified. Hiring unqualified counselors can lead to the kind of deterioration in the delivery of mental health services that Perry experienced in 2009-2010. Within a period of a few months, all five of Perry's counselors were fired or resigned under investigation or following a serious reprimand. As Dr. Patterson testified, those counselor departures had a significant effect on mental health services provided at Perry, resulting in the cancellation of many psychiatric clinics and group therapy sessions. Disciplinary reprimands in counselor personnel files give further evidence of the overall poor quality of SCDC counselor services.

In 2009, SCDC began conducting internal audits of its mental health counselors. As Dr. Patterson and Dr. Metzner testified, the audits document a wide range of serious counselor deficiencies. Scores were particularly poor for Lee, Lieber, and Perry, the male Area Mental Health Institutions, where 55 percent of the audits were either "unsatisfactory" or "satisfactory, but with major concerns." Some of the deficiencies listed are disturbing. They include numerous instances of mentally ill inmates going for many months without seeing a counselor or psychiatrist, in violation of SCDC policy; treatment plans that were out of date and incomplete; and inadequate documentation of medication administration and group therapy sessions. Some counselors repeatedly failed their audits.

The Court finds that inadequate mental health staffing at all levels within SCDC represents a substantial risk of serious harm to inmates with serious mental illness.

4. Maintenance of accurate, complete, and confidential mental health treatment records

A treatment plan is intended to be a dynamic and fluid process that continues on a regularly scheduled basis, supplemented by constant updates and revisions. In order to be effective, treatment plans must be accurate, complete, readily accessible to professional staff, and confidential. During trial, evidence was presented to the Court indicating that documentation and maintenance of these records is poor. The treatment plans and automated medical records ("AMR") do not clearly state problems, objectives, goals, or even identify plan-responsible staff.

The importance of maintaining accurate and complete treatment records is vital to any medical services delivery system. For mentally ill inmates in particular, treatment plans and AMRs are critical for assessing progress as well as the effect of medication and therapy.

In addition, Dr. Metzner offered several examples of basic information about its mental health program that SCDC's aged computer system is unable to provide. For example, SCDC's computer system cannot retrieve the names or numbers of all inmates referred to the ICS program; the number of women inmates referred to Geo Care for inpatient psychiatric services; the number of inmates who have made serious suicide attempts; or the number of inmates whose psychotropic medications have expired without being timely renewed.

In summary, the evidence in this case shows that the recordkeeping system for SCDC is outmoded, poorly maintained, and not readily accessible to all staff. The Court finds that SCDC's failure to maintain accurate and complete mental health treatment records represents a substantial risk of serious harm to mentally ill inmates.

5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation

In evaluating this factor, some of the same concerns overlap with those of the previous factor – maintenance of accurate, complete, and confidential mental health treatment plans. The Court, however, will note three specific issues that raise further concerns. First, Medication Administration Records ("MAR") of mentally ill inmates provide crucial information upon which psychiatrists rely. SCDC uses standard MAR forms where nurses are required to sign their initials to confirm that medication was provided and administered. At trial, various MARs were introduced indicating the absence of initials and absence of any record that medications were provided at all. This indicates either the medication was not provided or the nurses failed to maintain accurate records. For example, in October and November 2008, inmate Jonathan Mathis was prescribed one medication to be taken twice a day and two other medications to be taken once a day. From his MAR, however, it appears he received no medications either month, without explanation.

Although counselors monitor MARs, the Court agrees with Dr. Patterson that SCDC counselors are not qualified to do so, as evidenced by counselor audits showing deficient MARs. Ms. Delgado acknowledged that a failure to adequately monitor MARs has no effect on a counselor's audit score. For example, the only audit that one Lieber counselor has ever passed was an audit in which 14 of the 15 MARs reviewed for which she was responsible were found incomplete or outdated.

The second issue of concern involves the suicide of Robert Hamberg. SCDC records show that Mr. Hamberg's morning medications had expired – specifically his anti-psychotic medicine Geodon – which he was supposed to receive twice a day. Nevertheless, his counselor

was still recording that he was compliant with his medication – that he was receiving it in the mornings and evenings. Thus, Mr. Hamberg was only receiving half of his prescribed dosage of anti-psychotic medication. Mr. Hamberg committed suicide on June 9, 2010 at Perry Correctional Institution.

The third issue of major concern in the area of medication administration involves pill lines. As Dr. Patterson testified, medication compliance is especially difficult for many mentally ill inmates, due to medication side effects and the nature of their illness. At many institutions, pill lines occur between 3:00 - 4:00 a.m., and mentally ill inmates are often left to their own devices to timely awake, stand in line, and then take their medication. The timing, press of business, and lack of individual attention at the pill line lends itself to inmates failing to take psychotropic medications.

This Court finds that the failure to appropriately supervise, evaluate, and dispense psychotropic medications creates a substantial risk of serious harm to inmates with serious mental illness.

6. **A basic program to identify, treat, and supervise inmates at risk for suicide**

a. **The setting of Crisis Intervention ("CI") cells**

At trial, Dr. Patterson identified seven mentally ill inmates at SCDC, in addition to Jerome Laudman, whose deaths from 2008-2011 were both foreseeable and preventable.[11] In his opinion, two common factors contributed to these deaths. First, crisis intervention cells are located in segregation units, not in a medical setting, and thus lack sufficient medical interaction

[11] Six of these were suicides. The seventh, Stephen Jeter, was not ruled a suicide, but his death was related to a failed suicide attempt. Moreover, the Court is aware that two more SCDC inmate suicides occurred while this trial was actually in progress, one at Lee and one at Lieber, with both decedents either on or should have been on the mental health caseload.

and treatment. For example, CI inmates are not being assessed daily for mental health purposes. As of the date of trial, SCDC policy only required that inmates in CI be seen Monday through Friday, excluding holidays, and this policy is often violated. Inmates in CI cells spend the entire day in those cells, and are held for long periods of time – typically one to two weeks – but sometimes longer. CI cells, like other SMU cells, are cold and filthy, with trash, blood, and feces scattered or smeared about. Inmates are placed naked in CI cells. They often are not provided a blanket, and when one is provided it often is not clean. CI cells do not have mattresses. Inmates sleep directly on a cold steel or concrete slab. Inmate Richard Patterson testified how he tore up his Styrofoam food trays, then spread the pieces on his concrete slab to serve as a form of mattress. In addition, most inmates in CI do not see a psychiatrist and are not allowed group therapy. Interaction with counselors is brief, limited, and not confidential.

For at least a three-year period, from 2008-2010, correctional officers at Lieber, at times with the acquiescence of mental health staff and at other times without their knowledge, routinely placed CI inmates naked in shower stalls, "rec cages," interview booths, and holding cells for hours and even days at a time. Most of these alternative CI spaces did not have toilets and none were suicide resistant. Details of these placements are contained in Dr. Metzner and Patterson's inspection report, entered into evidence, as well as in their testimony and the testimony of various inmates. SCDC's own logs document over 100 of these alternative placements during the 27 months for which logs were provided.[12] The Court finds that the vast majority, if not all, of these placements were for inmates on crisis intervention. SCDC logs show that 55 of these placements at Lieber were for twelve hours or longer and 29 exceeded 24 hours. Inmate Isaac Anderson was confined over 86 consecutive hours in a Lieber rec cage from April

[12] SCDC could not locate Lieber SMU logs for several of the months requested.

2-6, 2009, with his first documented bathroom break coming after 42 hours in the cage. The interview booths and showers used for CI were often filthy and too small a space in which to lie down. Correctional officers brought CI inmates "finger food" meals to these spaces. Since inmates were not always provided bathroom breaks, some were forced to urinate and defecate in the same spaces where they were fed. Moreover, the Court finds that the use of such inappropriate spaces for CI has not been limited to Lieber. Plaintiffs presented inmate testimony and other evidence that SCDC has placed CI inmates in such spaces at other institutions prior to 2008 and after 2010. For the reasons discussed, the Court finds that SCDC's normal CI placements expose inmates with serious mental illness to a substantial risk of serious harm. The dehumanizing conditions of SCDC's alternative CI placements expose inmates to even greater risk.

b. **Lack of constant observation**

Second, SCDC's policy does not require constant observation; rather, inmates in CI cells are checked on 15-minute intervals, documented in cell-check logs. The evidence before the Court contains proven instances of fabricated cell check logs. For example, the cell check log of inmate Edward Broxton noted that at 6:30 a.m. on February 2, 2010, he was eating breakfast, even though an hour earlier, at 5:30 a.m., Broxton had hanged himself in his CI cell at Lee. Many of the cell check logs for Jerome Laudman were initialed "GM," although the only Lee Supermax correctional officer with those initials denied making the entries or authorizing anyone to use his signature. The SCDC Inspector General report on the drug overdose suicide at Perry of inmate James Bell documented evidence that his cell check logs had also been falsified. To make matters worse, on the Saturday before Bell's suicide his aunt, in an upset state, phoned SCDC to warn them of a "goodbye letter," suicidal in nature, she had received from her nephew.

SCDC mental health staff did not check on Bell until two days later, on Monday afternoon, when a counselor found him dead in his cell.

SCDC's expert, Dr. Haas, agreed with Dr. Patterson and Dr. Metzner that inmates on suicide watch require continuous observation. In 2008, inmate Brian Schriefer committed suicide while on CI at Gilliam by stuffing either toilet paper or a paper gown down his throat. As a result of Schriefer's death, SCDC stopped distributing gowns to CI inmates, instead requiring them to remain naked while in CI. SCDC did not change its policy, however, on continuous observation of suicidal inmates. Continuous observation would have prevented Schriefer's death.

The Court finds that SCDC's suicide prevention and crisis intervention practices create a substantial risk of serious harm to seriously mentally ill inmates.

7. Summary of objective component

As detailed above, this Court finds that the evidence in this case has proved SCDC's mental health program is inherently flawed and systemically deficient in all major areas. The Court further finds that a major contributing factor to the deficiencies in the SCDC program is the lack of a formal, comprehensive quality management program.

Finally, having observed the testimony of the psychiatric and correctional experts for both Plaintiffs and Defendants, this Court finds Plaintiffs' experts more credible. In part, this finding is due to a comparison of their credentials and experience; in part, due to their relative persuasiveness on the witness stand; and in part, due to the wide disparity between Plaintiffs' and Defendants' experts in case preparation and particular knowledge of the SCDC system.

Based on the testimony of these experts and the other evidence presented at trial, the Court finds that SCDC's mental health program exposes inmates with serious mental illness to a

substantial risk of serious harm. Plaintiffs have therefore satisfied the objective component of the deliberate indifference standard.

B. Subjective Component

The subjective component of the deliberate indifference standard requires proof that SCDC knew that Plaintiffs were exposed to a substantial risk of serious harm, but failed to take reasonable measures to abate the risk. *Farmer*, 511 U.S. at 847. The subjective component should be determined in light of the prison authorities' "attitudes and conduct at the time suit is brought and persisting thereafter." *Id.* at 845-846.

The evidence is overwhelming that SCDC has known for over a decade that its system exposes seriously mentally ill inmates to a substantial risk of serious harm. In 1999, SCDC retained Dr. Patterson (Plaintiffs' expert), through a grant, to inspect its mental health program. His report, issued in 2000, characterized the program as being in a state of "profound crisis." In October 2000, a Joint Legislative Proviso Committee report concluded that "inmates with mental illness are not receiving adequate treatment . . . and oftentimes leave prisons worse off than when they entered." In April 2003, a South Carolina Task Force whose members included three former SCDC Directors issued a report that concluded Gilliam was "clearly inadequate." In May 2003, the South Carolina Department of Mental Health issued a report on SCDC's mental health program, noting "[t]he lack of psychiatric coverage has resulted in a critical situation, with extremes of poor care, inhumane treatment, and dangerousness . . . ." In September 2003, SCDC Director Jon Ozmint, in an application for technical assistance, stated that "[t]he current plight of persons with mental illness at SCDC is at a crisis level." In June 2005, the Plaintiffs filed their Complaint in this case, alleging constitutional deficiencies in SCDC's program. From 2006-2010 Plaintiffs' experts issued eight site inspection reports criticizing conditions in SCDC

facilities. In October 2007, SCDC psychiatrist Dr. Michael Kirby wrote a letter to his supervisor noting several serious problems with SCDC's mental health system. In June 2008, SCDC investigator Lloyd Greer issued his report on the death at Lee Supermax of Jerome Laudman. From 2008-2010, Lieber SMU logs documented the use of shower stalls and other inappropriate spaces for CI placements. In 2009-2010, SCDC was aware that the counselor shortage at Perry created serious deficiencies in the delivery of mental health services. In January 2010, a United States Department of Justice report was highly critical of SCDC's medication management and administration practices. SCDC's own counselor audits from 2010-2011 revealed numerous unsatisfactory practices and major deficiencies. January 2012 internal data showed counselor-to-patient ratios at many SCDC facilities that were excessively high. Finally, through the discovery process in the litigation of this case from 2005-2012, SCDC was made aware of the serious allegations raised by Plaintiffs and their experts, many of which are supported by SCDC's own records.

33

The Court finds from this evidence that SCDC knows and has known, since before this lawsuit was filed, and persisting thereafter until the time of trial and even to present date, that its mental health program is systemically deficient and exposes seriously mentally ill inmates to a substantial risk of serious harm.

That, however, does not end the analysis. The second element of the subjective component focuses on action: has SCDC taken reasonable measures to abate the risks of which it is aware? The evidence shows that from 1999 until the filing of this action in 2005, SCDC did virtually nothing to address, much less eliminate, the substantial risks of serious harm to which class members were exposed. What limited action SCDC has taken since the filing of this lawsuit has had little to no effect in abating the unconstitutional deficiencies this Court has

found. "[T]o rely on intervening events occurring after suit has been filed the defendants must satisfy the heavy burden of establishing that these such events 'have completely and irrevocably eradicated the effects of the alleged violations.'" *Thomas v. Bryant*, 614 F.3d 1288, 1320-21 (11th Cir. 2010).

SCDC has failed to meet this "heavy burden." At trial SCDC identified the measures it has taken since 2005 to improve its mental health program. These include the hiring of two administrators and some administrative support staff, an increase in psychiatric staff FTEs, a re-organization of group therapy, a new protocol for addressing self-injuring behavior ("SIB"), mental health dorms, increased use of tele-psychiatry, new training programs for clinical and security staff, and counselor audits.

The Court finds that these are small steps that have had little impact on the systemic deficiencies in SCDC's mental health program. The mere hire of administrators to replace other administrators is not necessarily an improvement. Additional administrative support staff does not address the dire need for more clinical staff. Since 2008, SCDC's psychiatric staff has remained relatively flat and currently consists of 5.5 FTEs, although this Court has found that at least 14.5 FTEs are needed. As discussed, counselor and psychologist FTEs are far too low. Reorganized or not, group therapy sessions are frequently cancelled and unavailable for most inmates in segregation and crisis intervention. SCDC introduced no persuasive evidence that its new, decentralized SIB protocol has improved SIB-related issues. SCDC's concentration of some mentally ill inmates in designated dorms is no substitute for an adequately staffed mental health program. At the time of trial, SCDC had not implemented expanded tele-psychiatry services, but had merely requested a feasibility study. SCDC's training programs are limited in scope and poorly attended. Counselors are the only mental health clinicians subject to formal

audits, and those audits, though limited in scope, reveal alarming deficiencies. Despite a low bar for passing, many counselors fail their audits, some repeatedly.

Half-hearted measures will not foreclose a finding of deliberate indifference. "Patently ineffective gestures purportedly directed towards remedying objectively unconstitutional conditions do not prove a lack of deliberate indifference, they demonstrate it." Standards Order at 13, (quoting *Coleman v. Wilson*, 912 F. Supp. 1282, 1319) (E.D. Cal. 1995)). *See also Thomas*, 614 F.3d at 1320 (11th Cir. 2010) ("practices may be reinstated as swiftly as they were suspended"). The steps SCDC has taken have been small ones, characterized by SCDC itself as "band aids,"[13] many of which were instituted shortly before and even during trial, that have failed to adequately address the known systemic deficiencies in its mental health program. The SCDC mental health program needs far more than band aids, and the Court finds that the measures taken by SCDC to correct its systemic deficiencies are neither reasonable, timely, nor effective. Plaintiffs have therefore satisfied the subjective component of the deliberate indifference standard.

II. REMEDY TO ADDRESS CONSTITUTIONAL VIOLATIONS

A. Overview

In devising a remedy for the constitutional deficiencies at SCDC, the Court is required to balance two competing interests. First, it is not the role of this Court to micromanage the daily administration of the mental health program at SCDC. Moreover, this decision comes in a time of economic recession and heavy scrutiny of governmental expenses. However, "[c]ourts may not allow constitutional violations to continue simply because a remedy could involve intrusion into the realm of prison administration." *Brown v. Plata*, 131 S.Ct. 1910, 1928-29 (2011).

[13] SCDC's June 8, 2009 Memorandum on Applicable Standards contended that SCDC had a "well-developed mental health system . . . in place for decades," that needed nothing more than "band aids or other minor remedies."

Additionally, the economic "cost of protecting a constitutional right cannot justify its total denial." *Bounds v. Smith*, 430 U.S. 817, 825 (1977). "A plea of lack of funds is an insufficient justification for the failure of the executive department" to provide constitutionally mandated treatment programs. *Crain v. Bordenkircher*, 176 W.Va. 338, 364, 342 S.E.2d 422, 449 (1986), (quoting *Moore v Starcher*, 167 W.Va. 848 - 853, 280 S.E.2d 693, 696 (1981)).

Second, under the separation of powers doctrine, this Court may not usurp the authority of other branches of government. The separation of powers doctrine, however, "is not fixed and immutable." *State v. Langford*, 400 S.C. 421, 434, 735 S.E.2d 471, 478 (2012). On the contrary, the doctrine contains "grey areas" and an "overlap of authority" among governmental branches. *Id.*

> "Separation of powers does not require that the branches of government be hermetically sealed; the doctrine of separation requires a cooperative accommodation among the three branches of government; a rigid and inflexible classification of powers would render government unworkable." At its core the doctrine therefore "is directed only to those powers which belong exclusively to a single branch of government."

Id. (quoting 16A Am.Jur.2d, *Constitutional Law* § 244, 246).

In *Blaney v. Cmmr. of Corrections*, 374 Mass. 337, 372 N.E.2d 770 (1978), following defendants' submission of deficient plans to remedy prison conditions, the court entered a remedial order giving explicit directions for defendants to follow. The court rejected defendants' argument that the order violated separation of powers, noting that courts have power to direct public officials to carry out their lawful obligations. 374 Mass at 339-42, 372 N.E.2d at 773-74. "As to judges' authority to fashion detailed orders to correct established violations of constitutional rights . . . [s]uch functions are judicial, and in no way usurp the power of the executive." 374 Mass. at 342-43, 372 N.E.2d at 774, *citing Swann v. Charlotte-Mecklenburg*

County Bd. of Educ., 402 U.S. 1, 15 (1971); *U.S. v. Montgomery County Bd. of Educ.*, 395 U.S. 225, 234-36 (1969). *See also In re K.C.*, 325 Ill. App. 3d 771, 779-80, 759 N.E.2d 15, 23 (2001) ("When the legislature creates a statute that contemplates an interplay between the courts and the executive branch, court orders directing the actions of the executive agencies do not violate the doctrine of the separation of powers."); *Crain*, 176 W.Va. at 364, 342 S.E.2d at 449 (where a court ordered the West Virginia Department of Corrections to implement an extensive remedial plan addressing constitutionally deficient prison conditions.); *Haley v Barbour Cnty.*, 885 So. 2d 783, 790 (Miss. 2004) (noting court regulation of the number of inmates a county may deliver to a prison does not violate separation of powers.); *Massameno v. Statewide Grievance Comm.*, 234 Conn. 539, 567, 663 A.2d 317, 333 (1995) (stating a court does not violate separation of powers doctrine by supervising and disciplining executive branch prosecutors.)

Finally, this Court is bound to uphold the South Carolina Constitution and protect the rights of the mentally ill inmates at SCDC. Moreover, it is the action of a circuit court that triggers the placement of an inmate into the custody of SCDC, under Court authority, and thus this Court has the inherent power - and responsibility – to see that the imprisonment of that inmate complies with constitutional mandates. The Court is convinced that to view the evidence put forth in this case and then do nothing could be a great miscarriage of justice.

To address the constitutional deficiencies in the mental health system at SCDC, Plaintiffs have proposed a remedial plan comprised of three components. First, SCDC would be required to submit a written plan for remedying the systemic deficiencies identified by the Court. Second, SCDC must rely upon factors and guidelines identified by the Court in creating this plan, which the Court will then review and either approve or disapprove. Third, the Court will retain jurisdiction of this case and appoint expert monitors and/or a special master who will report

periodically to the Court. SCDC has raised objections to this plan, arguing that it constitutes an impermissible burden shift and is violative of the separation of powers doctrine.

The Court denies SCDC's objections. It would be highly impractical for Plaintiffs to identify and create a plan to implement changes to the mental health system at SCDC. Rather, once the Court has ruled, SCDC is in the best position to propose steps and changes to its existing system. *See Alexander S. v. Boyd*, 876 F. Supp. 773, 804-04 (D.S.C. 1995) (where a court ordered the South Carolina Department of Juvenile Justice to submit remedial plan within 120 days of order); *Crain*, 176 W.Va. at 341, 342 S.E.2d at 426 (where a court ordered the West Virginia Department of Corrections to submit remedial plan within 180 days of order). As a result, the Court adopts Plaintiffs' proposals and requires SCDC to submit a written plan to the Court within 180 days of the date of the Final Order in this case. In executing the remedial plan to be submitted by SCDC, the Court will retain jurisdiction but also intends to appoint a monitor who will report periodically to the Court. The Court will provide the parties, through motions, an opportunity to suggest the appropriate appointee(s) to oversee this process.

38

B. Remedial Factors and Guidelines

In formulating specific factors and guidelines for SCDC's remedial plan, the Court will again utilize the *Ruiz* factors above, along with additional sub-factors and components listed thereunder. In devising a plan to remedy the constitutional deficiencies identified by the Court, SCDC shall be directed in the Order to prepare a written plan that includes, at a minimum, the following:

1. <u>The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care</u>

   i. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of increasing the number of inmates recognized as mentally ill and being admitted to the mental health program by a minimum of two percentage points (14.9 percent of the inmate population);

   ii. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors;

   iii. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill; and

   iv. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.

JAS 39

2. <u>The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC</u>

   a. Access to Higher Levels of Care

   i. Significantly increase the number of Area Mental Health inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefor;

   ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefor;

   iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam

Psychiatric Hospital, or its demolition for construction of a new facility;

iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care; and

v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.

b. Segregation

i. Provide access for segregated inmates to group and individual therapy services;

ii. Provide more out-of-cell time for segregated mentally ill inmates;

iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;

iv. Provide access for segregated inmates to higher levels of mental health services when needed;

v. The collection of data and issuance of quarterly reports identifying the percentage of mentally ill and non-mentally ill inmates in segregation compared to the percentage of each group in the total prison population with the stated goal of substantially decreasing segregation of mentally ill inmates and substantially decreasing the average length of stay in segregation for mentally ill inmates;

vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and

vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

c. Use of Force

i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;

ii. The plan will further require that all instruments of force, (e.g, chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;

iii. Prohibit the use of restraints in the crucifix or other positions that do not conform to generally accepted correctional standards and enforce compliance;

iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;

v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs;

vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat;

vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;

viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;

ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;

x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates; and

xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.

3. **Employment of a sufficient number of trained mental health professionals**

i. Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;

ii. Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams;

iii. Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;

iv. Develop a plan to decrease vacancy rates of clinical staff positions which may include the hiring of a recruiter, increase in pay grades to more competitive rates, and decreased workloads;

v. Require appropriate credentialing of mental health counselors;

vi. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and

vii. Implement a formal quality management program under which clinical staff is reviewed.

4. **Maintenance of accurate, complete, and confidential mental health treatment records**

i. Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:

- Names and numbers of FTE clinicians who provide mental health services;

- Inmates transferred for ICS and inpatient services;
- Segregation and crisis intervention logs;
- Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);
- Use of force documentation and videotapes;
- Quarterly reports reflecting total use-of-force incidents against mentally ill and non-mentally ill inmates by institution;
- Quarterly reports reflecting total and average lengths of stay in segregation and CI for mentally ill and non-mentally ill inmates by segregation status and by institution;
- Quarterly reports reflecting the total number of mentally ill and non-mentally ill inmates in segregation by segregation status and by institution;
- Quality management documents; and
- Medical, medication administration, and disciplinary records.

ii. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.

5. <u>Administration of psychotropic medication only with appropriate supervision and periodic evaluation</u>

i. Improve the quality of MAR documentation;

ii. Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;

iii. Review the reasonableness of times scheduled for pill lines; and

iv. Develop a formal quality management program under which medication administration records are reviewed.

6. A basic program to identify, treat, and supervise inmates at risk for suicide

i. Locate all CI cells in a healthcare setting;

ii. Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;

iii. Implement the practice of continuous observation of suicidal inmates;

iv. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;

v. Increase access to showers for CI inmates;

vi. Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;

vii. Undertake significant, documented improvement in the cleanliness and temperature of CI cells; and

viii. Implement a formal quality management program under which crisis intervention practices are reviewed.

CONCLUSION

Even the most brief and facile view of the evidence put forth by Plaintiffs in this case reveals obvious, significant, and longstanding problems with mental health services delivery at SCDC. Prior to trial, this Court tried its very best to bring the parties together for settlement purposes, even requiring the Director of SCDC and the guardian for the Plaintiffs, attorneys for both sides, and other interested parties to meet in an effort to resolve the case. The Court was not present for these discussions and thus cannot determine why they were unsuccessful.

We are now eight years into this litigation. Rather than accept the obvious at some point and come forward in a meaningful way to try and improve its mental health system, Defendants

have fought this case tooth and nail—on the facts, on the law, on the constitutional issues, portraying itself as beleaguered by the burdensomeness of Plaintiffs' discovery, and generally harrumphed by the invasive nature of Plaintiffs' counsels' tactics and strategies. This Court has spent dozens of hours in hearings and conferences in an effort to resolve discovery disputes, most of which involved delay, missed deadlines, and recalcitrance on the part of the Defendants.

This Court can never criticize any party for a vigorous exercise of offense or defense in civil litigation, for such is the foundation of our adversarial system of justice. But justice in this case is not really about who wins or loses this lawsuit. The hundreds of thousands of tax dollars spent defending this lawsuit, at trial and most likely now on appeal, would be better expended to improve mental health services delivery at SCDC.

For the reasons set forth above, the Court grants judgment in favor of the Plaintiffs and orders SCDC to submit a proposed written remedial plan consistent with this Order.

IT IS SO ORDERED.

J. Michael Baxley
Presiding Judge
Complex Jurisdiction

Hartsville, South Carolina

January 8, 2014

Exhibit 2. *Radaszewski v. Maram*, Case No. 1:01-cv-09554, Entries 172 and 175 (N.D.Ill. 2008)

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DONNA RADASZEWSKI, Guardian, on behalf of Eric Radaszewski,	)	
Plaintiff	)	
vs.	)	No. 01 C 9551
BARRY MARAM, Director, Illinois Department of Healthcare and Family Services,	)	Judge John W. Darrah
Defendant,	)	

ORDER

For the reasons stated in the Court's Opinion and Order entered March 26, 2008, setting out the Court's findings of fact and conclusions of law:

IT IS HEREBY ORDERED:

(1) A Permanent Injunction is entered enjoining the defendant from reducing coverage for Eric Radaszewski to less than sixteen hours per day of skilled nursing services by a registered nurse (R.N.) seven days per week, at his parents' home, and an additional 336 hours of such skilled nursing hours per year as respite for his parents. These nursing hours will be covered at the rate utilized by the defendant for in-home registered nursing (R.N.) services in DuPage County, Illinois, at the time the service is provided.

(2) Plaintiff is awarded her costs of this litigation and litigation expenses, to be determined at a later date pursuant to Local Rules 54.1 and 54.3.

(3) This Court shall retain jurisdiction of this matter for purposes of enforcement of this Order.

Dated: 5-9-08

JOHN W. DARRAH
United States District Court Judge

HHR

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DONNA RADASZEWSKI, Guardian, on behalf of Eric Radaszewski,	)	
Plaintiff,	)	**No. 01 C 9551**
v.	)	
BARRY S. MARAM, Director of the Illinois Department of Healthcare and Family Services,[1]	)	**Judge John W. Darrah**
Defendant.	)	

OPINION AND ORDER

Plaintiff, Donna Radaszewski, filed suit, as guardian and on behalf of her son, Eric Radaszewski ("Eric"), against Defendant, Barry S. Maram, the Director of the Illinois Department of Healthcare and Family Services ("HFS"), in the Circuit Court of DuPage County, Illinois. Radaszewski sought, in part, injunctive relief compelling the IDPA to fully fund the cost of the private-duty nursing care that Eric required in order to remain at home. In December 2000, the state court entered a temporary injunction requiring the IDPA to restore funding to the Radaszewski family sufficient to pay for sixteen hours a day of private-duty nursing. That injunction remains in effect today. Subsequently, the suit was removed to federal court based on the addition of federal claims in Plaintiff's Supplemental Complaint. The federal claims alleged that HFS

[1]The original Complaint was filed against the then-director, Jackie Garner, of the Illinois Department of Public Aid ("IDPA"), now known as the Illinois Department of Healthcare and Family Services.

violated Title II of the American with Disabilities Act of 1990, 42 U.S.C. § 12132, ("ADA") and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, ("RA"), by refusing to provide medical services that Eric requires to remain in the most community-integrated setting to provide for his medical needs – specifically, his home.

In April 2002, the Court remanded Plaintiff's state-law claims to state court and retained jurisdiction over the remaining two federal claims. In October 2002, the Court dismissed Plaintiff's ADA claim, finding that Plaintiff could not sue the Director of HFS in her official capacity in federal court for relief under Title II of the ADA pursuant to *Walker v. Snyder*, 213 F.3d 344 (7th Cir. 2000), and granted judgment on the pleadings in favor of Maram on Plaintiff's RA claim. That decision was appealed to the Seventh Circuit Court of Appeals. In September 2004, the Seventh Circuit reversed and remanded the case, finding that *Bruggeman v. Blagojevich*, 324 F.3d 906, 912-13 (7th Cir. 2003), issued after this Court's decision, recognized that *Walker v. Snyder* had been overruled by the Supreme Court in *Board of Trustees of Univ. of Alabama v. Garrett*, 531 U.S. 356 (2001). Therefore, the allegations in the Supplemental Complaint permitted an inference that Plaintiff could prevail on her RA claim. *Radaszewski v. Maram*, 383 F.3d 599 (7th Cir. 2004) (*Radaszewski*).

Plaintiff's suit alleges that the IDPA's failure to fully fund, at-home, private-duty nursing for Eric constitutes disability discrimination in violation of the ADA and the RA, in that the state is refusing to provide the medical services that Eric requires to remain in the most community-integrated setting appropriate for his needs – his parents' home. The state contends that, under the

available state/federal programs, Eric may only receive $4,593 per month – the equivalent of five hours a day of private-duty nursing care – no further reasonable accommodations can be made to increase the amount Eric could receive.

The three factors considered in determining whether a state is obligated to provide community-based treatment for disabled persons are: (1) the state's treatment professionals find that community-based treatment is appropriate; (2) the affected individuals do not oppose community-based treatment; and (3) placement in the community can be reasonably accommodated, taking into account the state's resources and the needs of others with similar disabilities. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597-603 (1999) (*Olmstead*); *Radaszewski*, 383 F.3d at 608.

On September 10, 2007, a bench trial commenced on the ADA and RA claims. During the trial, the parties presented exhibits and testimony of witnesses, including expert witnesses.

The parties have submitted post-trial written arguments and proposed findings of fact and conclusions of law. The Court has considered the evidence, including the testimony of the witnesses and exhibits, and has further considered the written arguments of counsel for the parties and the authority cited therein. The Court weighed the testimony of each witness and determined whether the testimony was truthful and accurate (in part, in whole, or not at all) and decided what weight, if any, to give to the testimony of each witness. In making this determination, the Court considered, among other things: the ability and opportunity the witness had to see, hear, or know the things about which the witness testified; the witness's memory; any interest, bias or prejudice the witness may have; the witness's intelligence; the manner of the witness while testifying; and the reasonableness

of the witness's testimony in light of all of the evidence in the case. *See* Fed. Civ. Jury Instr. 7th Cir. §§ 1.13, 1.21 (2005). The Court also considered the testimony of expert witnesses in light of *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), and Federal Rules of Evidence 702 through 705.

Pursuant to Federal Rule of Civil Procedure 52, the Court enters the following written Findings of Fact and Conclusions of Law, which are based upon consideration of all of the admissible evidence and this Court's assessment of the credibility of the trial witnesses. To the extent, if any, that Findings of Fact, as stated, may be considered Conclusions of Law, they shall be deemed Conclusions of Law. Similarly, to the extent, if any, that Conclusions of Law, as stated, may be considered Findings of Fact, they shall be deemed Findings of Fact. The Decision section of this Opinion and Order, for purposes of organization and clarity, contains some reference to law and facts. To the extent, if any, that any part of the Decision may be considered Findings of Fact or Conclusions of Law, they shall be so deemed.

FINDINGS OF FACT

Eric's Medical Condition and Treatment Requirements

Eric, born in August 1979, was diagnosed in 1992 with medulloblastoma, a brain cancer. In 1993, Eric suffered a mid-brain stroke after undergoing surgery, radiation, and chemotherapy to treat the cancer. The cancer, stroke, and subsequent treatments have impaired Eric's physical and mental functions and left him with multiple and complex disabilities.

After several extended hospital stays, Eric resided at his parents' home and received twenty-four-hour care from multiple nurses and therapists. In approximately August 1995, Plaintiff's medical insurance terminated; and Plaintiff contacted HFS regarding receiving nursing services for Eric.

Eric is eligible for, and a participant in, the Illinois Medicaid Program. In Illinois, HFS is the single state agency responsible for administering the Medicaid Program. Illinois receives federal funds for the Medicaid program.

Eric was approved to receive healthcare services until he reached the age of twenty-one (August 2000). HFS provided funding for sixteen hours a day of private-duty nursing in Eric's home under the federally approved Illinois Medicaid Program for Medically Fragile, Technology Dependent Children ("MFTDC program"). This program was approved through an HFS waiver and provides a variety of home and community-based services and equipment for medically fragile persons under the age of twenty-one who would otherwise be required to be cared for in a skilled pediatric facility or hospital. *See* Ill. Admin. Code § 140.645. The MFTDC program's services include private-duty shift nursing and respite care in the recipient's home. The amount of services that an individual may receive under this program is determined with reference to the cost of the care the individual would require in a skilled pediatric facility or hospital. *See* Ill. Admin. Code § 140.645(c)(3).

When Eric obtained the age of twenty-one, the HFS reduced its reimbursement to $4,593 per month – the equivalent of five hours a day of private-duty nursing. Plaintiff filed an administrative appeal because the reduced funds were insufficient to provide the nursing services Eric required. The appeal was denied.

In 2000, an HFS hearing officer made factual findings about Eric's eligibility for the Home Services Program ("HSP") and the level of care that Eric required. These findings included the uncontradicted evidence that Eric would be at risk should he be placed in a nursing home because Eric could not receive the required level of care he needs in a nursing home. Specifically, the hearing officer concluded:

> A. Grievant [Eric] is a 20 year-old-man who was diagnosed with a medulloblastoma in 1992. He underwent surgery and chemotherapy for that condition. As a result of that condition and treatment for that condition, he has many physical disabilities and has lost both brain and bodily functions. He has been cared for at home for the past 5 years through funding from the Illinois Division of Specialized Care for Children (DSCC). This care, plus the admirable efforts of his parents, has allowed Grievant to be cared for in his home. Grievant wishes to be maintained in his home with his family; this is also his parents' wishes.
>
> * * *
>
> H. The uncontradicted evidence submitted by Grievant is that the Grievant would be at risk of danger if he should be placed in a nursing home. Grievant's doctor testified that Grievant needs substantial one-on-one nursing care to survive. He is medically fragile, prone to infections, immobilized, catheterized and relies on oxygen. A registered nurse is required to look for problems before they become "full blown and he crashes," according to Grievant's doctor. His immunological responses were severely compromised due to earlier radiation and chemotherapy, so skilled nursing care is a "question of survival, not a question of doing well." The physician strongly urged that Grievant be given the funds to support 24 hours per day of skilled nursing care. Placing Grievant in a nursing home facility of the type suggested by the State, according to the physician, would result in Grievant being seriously medically compromised, which would lead to many hospitalizations.
>
> I. Grievant's physician's opinion was supported by the registered nurse in charge of Grievant's care. He described Grievant's medical needs in detail. Grievant has no sense of thirst, so his hydration must be carefully monitored in order to avoid serious medical complications. Although Grievant has difficulty swallowing, he can be given soft food, but only under careful conditions. His nutrition

> must be carefully monitored. Grievant cannot protect his airway by turning his head; any aspiration of food, liquid or medicine can become a medical emergency. Chronic sinus infections lead to sepsis, which can be rapid and acute. Grievant also has osteoporosis and is in danger of breaking bones. His risk of injury is high because he sometimes forgets he cannot walk. His short-term memory is not good and he is often confused. He also has difficulty with urination and elimination, which if left untreated, can result in medical emergencies. Grievant has to be under constant surveillance.
>
> J. According to the expert witness offered by Grievant, Grievant could not get the level of required nursing care in a nursing home facility, including the facility suggested by the State (Alden Lincoln Park Nursing facility). In her assessment for this hearing, the expert contacted several nursing homes (including Alden) and asked about the level of care provided. According to the witness, none would provide the level of care need[ed] by Grievant: 24 hour[s] per day by skilled clinical nurses. She based her assessment on the Grievant's medical file, her observation of Grievant, and her 20 years of experience as a skilled nursing professional.

The Court heard testimony from Doctor Michael Peters, who has been Eric's primary care physician since September 2002. Dr. Peters is a licensed physician, holds several hospital appointments, is a diplomat of the American Board of Family Practice since 1990, and has been a fellow of the American Academy of Family Practice since 2006. Dr. Peters considers Eric to have a very complex medical condition ("Eric is probably the most complex medical case I have had to take care of during my medical career . . . ."). Eric's current medical conditions include the lack of any meaningful pituitary gland function, which makes Eric reliant on several hormonal preparations to maintain normal bodily functions. Eric is completely reliant on outside sources of hormonal support. Eric receives thyroid treatment, adrenal hormone, and a supplemental form of testosterone.

Eric is reliant on supplemental forms of nutrition given via hyperalimentation to maintain normal salt balances and chloric intake. He has difficulty absorbing and utilizing things properly by mouth so he requires intravenous administration.

Eric has an active seizure disorder that is treated with two different seizure medications. By virtue of Eric's disease state, Eric has a chronic immune suppressive condition that causes him to be very prone to infections, including pneumonia, urinary tract infections, and soft-tissue infections. These infections oftentimes require that Eric receive very strong antibiotic therapy through home intravenous antibiotic therapy. Eric's hormonal therapies have resulted in deformities of his bones and spinal column. Eric has trouble breathing properly and is prone to aspirating things he eats into his lungs. The spinal deformity is progressive and affects his ability to breathe, especially when he sleeps at night.

Eric is globally developmentally delayed. He communicates on a simple basis, but he cannot communicate how he feels very clearly in most situations. Eric receives between 20 to 25 different medications on a daily basis, and approximately 10 other medications on an as-needed basis for things such as nausea and pain.

In Dr. Peters' opinion, Eric requires private-duty nursing because he requires daily monitoring, vital-sign checks, and proper administration of his medications. This nursing would require a registered-nurse-level nurse who is experienced and knowledgeable and available to actively assess Eric on a daily basis. A nurse with this experience and knowledge would also be able to monitor Eric's condition to watch for interactions and complications from medications and

treatments and would be able to identify possible medical conditions early so treatment could be immediately instituted. Dr. Peters' opined that Eric's survival since the onset of his medical conditions is directly related to receiving private-duty nursing.

Dr. Peters does not believe that Eric could be properly treated in a nursing home because the number of patients that a nurse at a nursing home has to supervise and care for during the day would not allow the nurse adequate time to care for Eric. Furthermore. much of the daily care of patients in a nursing home is delegated to assistants. Dr. Peters' "concerns" with Eric's being in a nursing home include the risk that Eric would not appropriately receive treatments, resulting in infections due to Eric's decreased immune system, and the regularity of infections occurring in nursing homes, which would result in Eric's likely succumbing to repeated infections and would result in repeated hospitalizations. Dr. Peters testified:

> I believe the severe nature of his disabilities, the constellation of problems that he has, quite frankly, I don't think he would get the care he would need. In fact, it would create more problems for him putting him in a nursing home setting. I truly believe he would not do well in that setting.

Eric's medical condition at the time of trial was essentially the same as it was in August of 2000.

Ms. Radaszewski, Eric's mother, testified that Eric requires one-on-one nursing services to be cared for at home. Eric has no short-term or long-term memory so he is not aware of what he is doing much of the time. Eric has a ventriculoperitoneal shunt, a catheter placed in his brain for drainage to keep pressure in Eric's brain under control. Eric is wheelchair-bound and cannot effectively walk. He uses a platform walker with belts to be moved short distances, such as five steps to get to a chair or toilet. He also needs someone to watch for seizures, hydrocephalus, and shunt malfunctions. He has a skin condition that creates half-dollar-size sores of blood and pus.

These sores appear without warning and must be dressed to keep Eric safe from infection. Eric also has a double-lumen "PIC" line. This intravenous line is used to administer drugs and to feed Eric at night, at which time he receives an eight-hour IV solution of total parental nutrition ("TPN"). Eric needs assistance with eating because he aspires and chokes.

The services that Eric receives are from registered nurses because they have the experience and knowledge required for Eric's care. Eric's typical day starts anywhere from 7:00 a.m. to 11:00 a.m. when he gets up. A nurse either gives Eric a bath or shower after taking down Eric's TPN line, flushing the IV lines, and administering all of the IV medications for the morning. The nurse also separates Eric's pills that are taken throughout the day.

At the time of trial, Eric was receiving sixteen hours of private-duty nursing per day and 336 hours of respite hours per year pursuant to the injunction entered previously by the state court. Eric's parents provide Eric's care during the remaining eight hours a day. During this time, Eric usually takes a nap; and his parents provide him his medications. The medications are "pre-prepared" for Eric's parents, and written instructions are provided. His parents also watch for fevers and seizures, take him out to eat, and take him outside of the home on other occasions. In the event of any unusual symptoms, Eric's parents, as instructed, contact medical professionals. Eric has equipment in the home to aid in lifting him, and his father generally assists in lifting Eric. Eric's parents (his mother was 59 years old, and his father was 60 years old at the time of trial) have difficulties in providing care for Eric due to their age and their own medical conditions.

At home, Eric watches videos and likes to put things together. He likes to paint, color and draw. A nearby friend that has cerebral palsy comes to the home and plays with Eric. Eric also enjoys going to the movies, shopping, and going to restaurants.

The state's treatment professionals have found that community-based treatment is appropriate; and the affected individuals, Eric's guardians and Eric, do not oppose community-based treatment[2]. If institutionalized, Eric would require the equivalent of the private-duty nursing care that he has received at home. A hospital setting would provide the equivalent care to the care Eric receives at home with monitoring devices, telemetry, and the increased nursing staffing available in hospitals.

The cost of Eric's care in a hospital would exceed the cost of his care in the community, including both the sixteen hours per day of skilled nursing he receives at home and any ancillary medical costs. For example, in its last cost estimate preceding Eric's twenty-first birthday, the state estimated the institutional cost of Eric's care to be $29,330.40 per month, while the cost of his care plan at home – including sixteen hours of nursing services per day, supplies, equipment, and other therapies – was $20,868.19 per month. The cost of Eric's care in 2005 (the most recent year with complete data) was $20,499 per month or $676.53 per day. The average Medicaid reimbursement for hospital stays longer than 120 days for persons twenty years old or older was $1,428 per day for July 1, 2004 through October 28, 2005. Hospital reimbursement rates have not decreased since that time.

Illinois Healthcare Programs and Services

Frank Kopel is the chief of the Bureau of Program and Reimbursement Analysis ("BPRA") of HFS. One of the units or functions of the BPRA is the policy unit that oversees the state Medicaid plan. The state Medicaid plan is a contract between the State of Illinois and the federal government,

[2]As pointed out by the Seventh Circuit, the first two conditions – the propriety of community-based care for Eric and the consent of Eric and his affected family members – are undisputed. *See Radaszewski*, 383 F.3d at 608.

controlling the operation of the Medicaid program by the State of Illinois. The federal government requires each state to designate a single agency to be responsible for the Medicaid program in the state; in Illinois, that agency is HFS. A "waiver" is a provision by which the federal government allows the state to provide services that are not otherwise covered under the state Medicaid plan.

Medical providers in the Medicaid program are individuals or institutions that have agreed to provide services in compliance with the Medicaid state plan, to accept certain reimbursement as payment in full, and to abide by all of the rules and regulations of the state and federal Medicaid programs. The federal government reviews and approves the state Medicaid plan and provides approximately 50 percent of the funding for Medicaid. The amount of funds provided by the federal government is known as the federal financial participation ("FFP").

The state plan lists services and the amount of reimbursement for those services that are covered under the state plan. The state plan also lists eligibility for these services. Per the federal government, certain services must be provided; these are mandatory coverage services. Other services are provided but are optional services.

Early periodic screening, diagnosis and treatment services ("EPSDT") is a mandatory program for individuals under the age of twenty-one. Under this program, the state must provide any service that is listed in Section 1905(a) of the Social Security Act that is medically necessary to individuals under the age of twenty-one. These mandatory services are provided irregardless of whether they are available to the rest of the population. Private-duty nursing is an example of a service provided for under EPSDT that is not included in the State of Illinois Medicaid plan.

Private-duty nursing is one-on-one care provided to a person who has that medical need. Once an individual reaches the age of twenty-one, services otherwise provided under EPSDT are no longer available because that individual is no longer eligible for those services based on that individual's age.

The HSP is a program designed to assist individuals with severe disabilities to remain in their home and receive services instead of residing in a nursing facility. The HSP is authorized by the persons-with-disabilities waiver. The BPRA financially monitors the HSP by reviewing claims to enable securing matching federal funds and by reviewing the cost allocation plan of HFS to see that the portion of their costs that are attributable to Medicaid are reasonable and that they are adequately documented.

The HSP is a very cost-effective program. In 2005, HFS reported that there were 19,827 participants in the HSP waiver and that the cost per participant for care in the community was $19,140 per year, while the estimated cost for care in the institutional setting was $32,816 per participant per year, a savings of $13,676 per participant per year.

For a claim to qualify for matching funds, it must: (1) be a covered service under the state plan or a waiver, (2) be provided to a Medicaid-enrolled and eligible individual, and (3) be provided by an enrolled provider.

As to hospital coverage under the Medicaid plan, there is no limitation on the number of days an individual can stay per year in a hospital. There are no facilities that are owned and operated by the state, specifically for long-term care of persons with disabilities.

Hospitals are reimbursed on a diagnosis-related grouping ("DRG"). The entire range of diagnoses are grouped into groups or classes of care that have similar resource utilization. When a claim comes in, a diagnosis and related procedures are analyzed with a computer program; and they are classified into one of these groupings. The price is then based upon the classification grouping for the services. In other words, there is an expected duration of stay based on the diagnosis code; and the hospital is reimbursed on that basis. The reimbursement is a "flat" reimbursement, unrelated to the actual length of stay; whether it is one or more days, the reimbursement is based upon the statistical computation. The hospital can get additional payment other than what was otherwise given under the DRG if the individual requires care longer than what would have been expected under the DRG. Long-term hospital stays are reimbursed on a per diem basis.

Barbara Ginder is the bureau chief of the Bureau of Interagency Coordination ("BIC") for HFS. The BIC is the liaison with other agencies that have day-to-day operation responsibilities of home and community-based waivers and other medical programs. This included waivers for HFS services, including a home and community-based waiver for a persons-with-disabilities waiver and a MFTDC's waiver. Both of these programs seek to provide services in the community that are appropriate for the person at no greater cost to the department than it would be if the person was in an institution. If HFS did not comply with the requirements of a waiver, the waiver could be terminated; and the state would lose the federal matching funds for the services provided under that waiver.

"Comparability" refers to the requirement that if a service is offered under the state plan, it has to be offered in the same way to anybody that has that medical need. Under a person with disabilities waiver, comparability can be designed individually so that certain limits can be imposed on certain services or be designed for certain kinds of disability groups or ages or medical conditions.

The federal government requires that all home and community-based waivers have cost neutrality – HFS cannot spend more money than would be spent for that same individual in an institutional setting. HFS measures cost neutrality on an average – across all participants in the program. In other words, HFS compares the projected waiver costs for all people in the waiver with the expected cost of the same population in a nursing home. However, the state can choose whether it wants to require every person to show that their cost is less than the cost of the alternate care in the institution or to let some individuals be above that cost and some below the cost, as long as the aggregate is cost-neutral. Under the person with disabilities waiver, the level of care comparison and institutional cost limit is that of a nursing facility.

Service cost maximums are cost caps based on the individual's determination-of-need score. The determination-of-need score is calculated based on what kind of impairment the individual has and what kind of support is needed. The determination-of-need scores range from 29 to 100. As the determination-of-need score rises, so does the cost cap.

If an individual is approved for a waiver and chooses the waiver of services over a nursing home, the individual and a case manager develop a service plan. The service plan outlines the kinds of services the individual needs, including the type and frequency of services, as well as who would provide such services. The service plan must be approved by the individual's physician.

An individual's written plan of care is a service plan that is created with the consumer's choice in mind with the assistance of a case manager and other providers as needed to develop the most comprehensive plan of care to maintain this individual in the community setting. The concept of consumer direction for a person with disabilities waiver allows the individual to hire, train and fire their own staff and allows an individual to put together a service package that best meets his needs and helps him become as independent as possible and have the quality of life that he requires.

Skilled nursing services are available to individuals under the person with disabilities waiver. There is no limitation on the number of hours per day that an individual in the HSP can have in terms of skilled nursing in their home other than a fixed-cost cap that is assigned to that individual. Accordingly, eight or more hours of skilled nursing in the home could be approved for an individual.

An exceptional care rate is a rate developed in the long-term care system for individuals who have exceptional or extraordinary medical needs. The long-term care system developed as a way to move individuals out of a hospital-based care to nursing homes. Exceptional care rates are utilized in the HSP and function the same as the service cost maximums, providing the upper limit of cost that the individual can seek for services per month.

The state has flexibility to meet the needs of persons who have problems of medical complexity. Effective January 1, 2007, the exceptional care rates that previously were applied to reimburse nursing homes to care for persons falling within categories of exceptional care needs were terminated when the Illinois Medicaid Program converted its nursing home reimbursement rates to a new reimbursement scheme. However, HFS continues to apply exceptional care rates to some HSP participants, even though such exceptional care rates are not in fact current nursing home rates and are fictional rates. Illinois law authorizes exceptional care rates up to the amount of a hospital rate.

Thomas R. Napolski is a vocational rehabilitation counselor for HFS. Previously, Napolski was a case counselor for the HSP. As a case counselor for the HSP, Napolski assessed individuals to identify if they were eligible for the HSP and to find appropriate types of services that would serve the disabled individual's needs. Napolski was Eric's case counselor. Eric was referred for the HSP on October 4, 1999. Eric was found to be eligible for the HSP in August 2000 and received services for the month of August 2000. Eric's case is now in "interrupt" status so he is not receiving services under the HSP. Eric continues to receive funds pursuant to the injunction that the state court entered in December 2000.

HFS can submit amendments to a waiver to the federal government for approval. All of the requests for amendments to waivers HFS filed as to waivers in the last ten years have been approved by the federal government.

Reasonableness of the Proposed Accommodation

Todd Menenberg, the Managing Director at Navigant Consulting ("Navigant"), is an economic analyst and rendered several opinions for the Defendant as an expert. Navigant is a leading firm nationally working with Medicaid, including Medicaid waiver issues. Menenberg opined that if all 26,000 individuals then in the HSP asked for and received an increase in the amount of services that they received up to the service cost maximum, the total annual cost of the program would be $206,000,000. If the 26,000 individuals asked for and received an increase in the amount services equal to that Eric seeks (250 percent), the total annual cost of the program would be $472,000,000. Menenberg's opinion in this regard is based, in part, on the premise that if Eric

was allowed to receive additional funds (essentially removing his service cost plan), all of the 26,000 individuals would also request and be permitted to avoid their service cost plan and receive funds up to the service cost maximum.

Based on a study conducted by Menenberg, at the time of trial there were approximately 9,000 Illinois Medicaid residents under the age of sixty that resided in nursing facilities. Menenberg also opined that approximately 12 percent of these 9,000 individuals would live at home if they could receive all of their nursing care at home. Menenberg estimates that the annual cost to the state, if these individuals received such care at home instead of in a nursing facility, would be $32 to $33 million annually.

Menenberg further opined that if the service plans were removed as a restrictive device and if individuals under a waiver or in a nursing home could avail themselves of a waiver and receive as much as they believed they needed, the total estimated annual cost for the first year would be between $238 million to $505 million.

Samuel Flint, Ph.D., an assistant professor of public policy at Indiana University Northwest, testified on behalf of Eric. He opined that Menenberg's conclusions were based on unsupported assumptions and resulted in unreliable conclusions. Dr. Flint pointed out that Meneberg assumed that all participants would seek additional services up to the maximum amount allowed and would receive such additional services without regard to the existing utilization review process that requires a medical need for services. Also, Menenberg's analysis, with respect to the nursing home population, failed to apply proper statistical standards, such as an actuarial analysis. In addition, Dr. Flint noted that Menenberg used non-random judgmental sampling in determining the possible

increased costs based on individuals', presently in nursing homes, moving to community care. Non-random judgmental sampling could not be used to reliably extrapolate the possible increased costs for in-home nursing. Furthermore, the assessments of the costs associated with the sample individuals' moving to community care failed to take into consideration other relevant factors, such as participation by family members in community, in-home care of the disabled person.

Dr. Flint also disagreed with Menenberg's conclusion that if Eric received the requested community-based treatment, precedent would dramatically affect the cost to the state for care of current nursing facility residents and for persons with disabilities waivers because the state Medicaid Program has ways to accommodate very ill individuals, such as Eric – for example, exceptional care rates. Dr Flint opined that if Eric received the needed funds, increasing the cap on funds he could receive, only 864 other people could seek an increase in their funding. If these 864 individuals received an increase of 10 percent, the increased cost to the state would be $152,000. If these 864 individuals received a 30 percent increase, the increased cost to the state would be $456,000. In Dr. Flint's opinion, only 143 other individuals would move from a skilled nursing facility to community-based treatment, as compared to Menenberg's estimation of 1,100 individuals' moving to community-based treatment and the estimate of Matthew Werner (another defense expert discussed below) of over 5,700 individuals' moving into community-based treatment.

Dr. Flint's opinions were based on sufficient facts and reliable principles and methodology. Dr. Flint further applied the principles and methods reliably to the facts. Dr. Flint's expert testimony was credible and persuasive.

Menenberg's analysis and testimony was not based upon reliable principles and methodology and was not credible or persuasive. Menenberg's opinions consist of calculations without supporting rationale as to his methodology and its application to other purported individuals similar to Eric. His calculations are based, in part, on the unsubstantiated premise that if Eric is permitted to exceed the cost cap imposed for his care plan, then all 26,000 participants in the HSP would also request and be entitled to receive services up to their service cost maximum, or 10 percent, 20 percent or 250 percent of their service cost maximums. Menenberg does not attempt to identify any persons participating in the HSP who require the amount and types of services that Eric requires. Rather, Menenberg's methodology consists of taking the number of the HSP recipients and calculating the benefits they are receiving now and the maximum benefits they could receive, whether or not those HSP participants need additional care or services. Menenberg fails to provide an explanation as to his assumption that utilization review would essentially be eliminated and that individuals will automatically avail themselves to services if they are offered at no cost.

With respect to Menenberg's projection that the state will incur $32 to $33 million in additional costs for individuals presently in nursing homes who may want to return to the community if Eric prevails, Menenberg fails to identify persons presently in nursing homes whose needs are not being met at the nursing home level of care and are comparable to Eric (whose needs cannot be met at a nursing home level of care).

Furthermore, Meneberg's methodology in estimating these costs by sampling 28 of 216 cases to arrive at an estimate for the entire census of approximately 9,000 persons with respect to nursing home residents was flawed because Menenberg, as mentioned above, used non-random judgmental sampling and lacked reliability because his methodology was a census, not a sample of the

population. Menenberg could not identify who selected the 28 persons in the sampling. The sole person who assessed those individual cases, an HFS nurse, used only the Minimum Data Sets ("MDS") of the 28 individuals and did not take into account other relevant factors, such as the care available to those persons at home, in making her assessments.

Matthew Werner, the former advisor to HFS on healthcare finance and former Chief of HFS's Bureau of Rate Development and Analysis, also offered "expert" testimony for the defense. He opined that if Eric received twenty-four hours of skilled nursing care in his home the additional cost to the state for persons residing in nursing home facilities and receiving twenty-four hours of skilled nursing and persons participating in the HSP receiving the same reimbursement as Eric could be $2.2. to $3.3 billion annually. However, Werner's methodology was not based on any projections of the number of persons who would leave nursing facilities because of a decision favorable to Eric nor the actual cost of services to the state as a result thereof. Instead, Werner estimated the potential *maximum* impact. Werner did not know how many individuals would shift to community services and did not know how many individuals would qualify for the same type of services Eric receives. Werner did not use standard actuarial methodology, which would have statistically determined the estimate of expected cost based on expected utilization, not the maximum possible cost.

Importantly, Werner's analysis failed to take into account medical necessity and assumed that a judgment in Eric's favor would essentially obviate medical necessity and the utilization review. Werner could not specify as to how many persons would qualify to receive Eric's level of services, how many individuals would shift from a nursing home to home care, nor could he testify as to

Eric's medical condition or needs and how those conditions compared to the needs of persons presently in nursing homes or in the HSP. Werner's analysis and testimony were not based upon reliable principles and methodology and were not credible or persuasive.

CONCLUSIONS OF LAW

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. A "qualified individual with a disability" is defined as one who "with or without reasonable modifications to rules, policies, or practices . . . meets the essential eligibility requirements of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2). A "public entity" includes "any State or local government" and "any department, agency, special purpose district or other instrumentality of a State . . . or local government." 42 U.S.C. § 12131(1)(A), (B).

Pursuant to Title II, the Attorney General has promulgated regulations, providing that "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The "most integrated setting appropriate" is defined as "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, App. A, p. 450. Although a public entity must make modifications as "are reasonable" in order to avoid unduly segregating the disabled, the public entity does not need to make such modification if it can show "that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7).

The RA, which applies to programs receiving federal funds, includes a similar anti-discrimination provision, 29 U.S.C. § 794(a), and corresponding regulation, requiring that a recipient of federal funding administer its programs and activities "in the most integrated setting appropriate to the needs of qualified handicapped persons," 28 C.F.R. § 41.51(d). Also consistent with the ADA, the RA's integration mandate provides that a recipient of federal funding need not accommodate a disabled person when the proposed accommodation would impose an "undue hardship" on the recipient. 28 U.S.C. §§ 41.53, 42.511(c); 45 C.F.R. § 84.12(c).

The relevant provisions of the ADA and the RA and their implementing regulations are construed in the same manner. *See Radaszewski*, 383 F.3d at 607.

"[U]njustified institutional isolation" of a disabled individual receiving medical care from a state institution constitutes an actionable form of discrimination under Title II. *Olmstead*, 527 U.S. at 597-603. Institutional placement of individuals who can benefit from community-based settings perpetuate "unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life"; and institutional confinement "severely diminishes the everyday life activities of individuals, including family relations, social contacts . . . and cultural enrichment." *Olmstead*, 527 U.S. at 600-01. Thus, a state may violate Title II if it refuses to provide an existing benefit to a disabled individual that would enable that person to live in a more community-integrated setting. *See Radaszewski*, 383 F.3d at 609; *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1182-84 (10th Cir. 2003); *Townsend v. Quasim*, 328 F.3d 511, 516-20 (9th Cir. 2003).

A state is obligated to provide community-based treatment for disabled persons if: (1) the state's treatment professionals find that community-based treatment is appropriate; (2) the affected individuals do not oppose community-based treatment; and (3) placement in the community can be reasonably accommodated, taking into account the state's resources and the needs of others with similar disabilities. *See Olmstead*, 527 U.S. at 607; *Radaszewski*, 383 F.3d at 608.

Under the fundamental-alteration defense, the public entity may demonstrate that it should not be required to accommodate the disabled individual by showing that adapting existing institutional-based services to a community-based setting would impose unreasonable burdens or fundamentally alter the nature of its programs and services. *See Olmstead*, 527 U.S. at 603-06; *Radaszewski*, 383 F.3d at 611, 614.

DECISION

Based on the foregoing, Plaintiff has sufficiently stated and proved a claim under the ADA and RA. *See Olmstead*, 527 U.S. at 597-603; *Radaszewski*, 383 F.3d at 609. Defendant argues that neither the ADA nor RA provide for an independent claim for integration in the community and that the authorities cited by Plaintiff do not recognize an independent claim for integration. Defendant's arguments are meritless and directly contrary to *Olmstead* and *Radaszewski*. *See Olmstead*, 527 U.S. at 597-603; *Radaszewski*, 383 F.3d at 608 ("In view of the integration mandate, the [*Olmstead*] Court agreed . . . that a State is obliged to provide community-based treatment for individuals with disabilities . . . ."). Defendant also argues that the Seventh Circuit's decision in this case, *Radaszewski*, 383 F.3d 599, is "of no aid" to the Plaintiff because it does not constitute a decision

on the merits. However, while the Seventh Circuit's ruling is not "a decision on the merits," it still constitutes controlling case law and must be followed by this Court where applicable. *See United States v. Krilich*, 178 F.3d 859, 861 (7th Cir. 1999); *United States v. Glaser*, 14 F.3d 1213, 1216 (7th Cir. 1994).

Eric is a qualified individual with a disability under the ADA and the RA. HFS is a public entity under the ADA and the RA. Eric and his parents do not oppose community-based treatment and specifically seek to allow Eric to remain at home and receive the same level of care he has been receiving for the last several years.

Eric has severe, long-term disabilities. Eric is eligible to receive services through the Illinois Medicaid Program. Eric is at risk of being placed in an institutional setting, and Eric is qualified to receive services through the HSP. Community-based treatment is an existing benefit under the Illinois Medicaid Program and is appropriate for Eric.

Eric's medical condition requires he receive the equivalent of the private-duty nursing care he presently receives at home. If Eric was placed in an institution, he would require the equivalent of the private-duty nursing care he presently receives at home but still would not receive the level of necessary treatment and health care if so placed. Rather, a hospital setting would be necessary to provide Eric with the proper treatment and care that he requires. Providing Eric sixteen hours per day of skilled nursing care in his home and ancillary costs associated with this health care costs less than the cost of Eric's health care if he was placed in a hospital.

If Eric was required to be placed in an institution, Illinois would be required to provide Eric the necessary level of health care – constant monitoring and continuous skilled assistance in accomplishing basic bodily functions. The services that Eric requires and presently receives at home

are, in substance, the services that would be required in a hospital. The unrebutted evidence clearly shows that the cost of caring for Eric in the proper institutional setting – a hospital – would be substantially greater than the cost of allowing Eric to remain in the community and receive the same proper treatment and health care. Allowing Eric to remain in the community can be readily accommodated, taking into account Illinois' resources and the needs of others with similar disabilities. Illinois can approve an HSP plan for Eric that exceeds the nursing home rate. If otherwise necessary, Illinois could also modify or alter the waiver from the federal government, which encourages the states to use home and community-based waivers to meet the community integration contemplated by *Olmstead*. Illinois could act in cooperation with the federal government to achieve community-based integration which may otherwise be impeded by existing rules or requirements. Thus, there is no need to adapt existing institutional-based services to a community-based setting that would impose unreasonable burdens or fundamentally alter the nature of Illinois' services and programs.

Illinois has not demonstrated that providing the requested accommodation to Eric would impose an unreasonable burden on the state or fundamentally alter the nature of its programs and services. The evidence offered by the state, including the flawed "expert" testimony of Menenberg and Werner, has not shown that Eric's healthcare needs cannot be reasonably accommodated by community placement considering the state's resources and the needs of others similarly disabled.

CONCLUSION

For the foregoing reasons, judgment is entered in Plaintiff's favor and against Defendant on Plaintiff's ADA and RA claims. The parties are ordered to meet, confer, and submit a proposed order, setting forth the appropriate relief, consistent with the holding of this Opinion and Order, on or before April 18, 2008.

Dated: March 26, 2008

JOHN W. DARRAH
United States District Court Judge

Exhibit 3. *Wilborn v. Martin*, Memorandum Order dated August 15, 2013

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

JEREMY WILBORN, By next friend and Conservator, TARA WILBORN, Plaintiff, v. LARRY MARTIN, Interim Commissioner, Tennessee Department of Finance and Administration; DARIN GORDON, Deputy Commissioner and Director, Bureau of TennCare; and PATTI KILLINGSWORTH, Assistant Commissioner, Chief of Long-Term Care, Bureau of TennCare, Defendants.	)	CASE NO. 3:13-00574 Chief Judge Haynes

MEMORANDUM

Plaintiff, Jeremy Wilborn, by his next friend and conservator, Tara Wilborn, filed this action under 28 U.S.C. § 1331, the federal question statute against the Defendants: Larry Martin, Interim Commissioner, Tennessee Department of Finance and Administration; Darin Gordon, Deputy Commissioner and Director, TennCare Bureau and Patti Killingsworth, Assistant Commissioner, Chief of Long-Term Care, TennCare Bureau. Plaintiff asserts claims under the Americans with Disabilities Act ("ADA") 42 U.S.C. §§ 12131-12165 and Section 504 of the Rehabilitation Act ("RA") 29 U.S.C. § 794(a) for the Defendants' alleged discrimination on the basis of his disability. Plaintiff, who has quadriplegia, is an enrollee in Tennessee's TennCare, a

Medicaid program administered by the Defendants. Plaintiff who was a minor, receives daily home health care services, but as an adult the Defendants informed Plaintiff of a substantial reduction in these benefits. For his ADA and RHA claims, Plaintiff alleges that as a qualified person with a permanent disability, the Defendants discriminated against him by severely limiting Plaintiff's existing benefits, that will result in Plaintiff's unjustified institutionalization in a nursing home in violation of the ADA and the RA.

Before the Court is Plaintiff's motion for preliminary injunctive relief (Docket Entry No. 4) contending, in sum, that notwithstanding Plaintiff's treating physician's medical assessment that Plaintiff's medical condition requires twenty four hours of care for seven days a week, the Defendants' TennCare plan limits Plaintiff's home health benefits to a maximum of 40 hours per week of home health care that are insufficient for Plaintiff's prescribed medical care. Plaintiff cites potential additional services under the Defendants' Home and Community Based Services (HCBS) under the Defendants' CHOICES program, but the Defendants refuse to provide them. In sum, Plaintiff asserts that the Defendants' cost limitations for services in their CHOICES program will force Plaintiff's institutionalization despite Plaintiff's previous rejection by a nursing home due to his medical treatment needs.

In response, Defendants contend, in essence, that given the State's comprehensive and effective plan for home and community-based services to persons with disabilities, the TennCare benefits and other accommodations offered to Plaintiff do not violate the ADA or RA. Moreover, Defendants assert that any alternation of those benefits to provide Plaintiff his prior health care regimen will cause a fundamental alteration of its TennCare plan that is prohibited by Olmstead v. L.C., 527 U.S. 581(1999). Further, to provide Plaintiff home medical services at costs that

exceed the Defendants' individual cost cap or limitation, is not a reasonable accommodation given the State's limited resources and the needs of other individuals with disabilities for the State's CHOICES program.

For the reasons set forth below, the Court concludes that Plaintiff's proof establishes a substantial likelihood of success on his ADA and RA claims. The Court finds that Plaintiff, as a person with a serious and permanent disability, will suffer severe risk of irreparable harm if he is confined at a nursing home. Plaintiff was previously released from a nursing home due to the demands of his medical care. The TennCare program for minors had determined that Plaintiff was in need of his current home care services. Plaintiff presented a home care services plan for his continuing care that is consistent with the Defendants' CHOICES program. The preliminary injunctive relief to effect Plaintiff's medical care plan does not present a fundamental alteration of the Defendants' CHOICES program nor pose any injury to any enrollee or prospective enrollee in the CHOICES program.

A. Findings of Fact

1. Plaintiff's Medical Care History

Plaintiff suffered an anoxic brain injury as a result of a suicide attempt in 2006 and enrolled in TennCare in January 2007. (Docket Entry No. 16, Dr. Willis Declaration at ¶¶ 3, 5). Plaintiff now receives twenty four hour home health care services at his residence from a private duty nurse who provides twelve hours care and a home health aide who also provides twelve hours care. (Docket Entry No. 16, Dr. Willis Declaration at ¶¶ 5, 8). Plaintiff is unable to attend to his bodily needs and is unable to communicate except that family members interpret his facial

expressions and sounds as communicating with them. (Docket Entry No. 15, Swiney Declaration at ¶ 21, and Docket Entry No. 4, Exhibit B at ¶ 2 and Exhibit C at ¶ 3). Tara Wilborn, Plaintiff's mother, who is also his conservator, testified that Plaintiff enjoys activities outside the home, such as family gatherings movies, shopping and attending Church, with the assistance of others. (Docket entry No. 4, Exhibit B at ¶ 9).

In February 2009, Plaintiff intervened as a plaintiff in Crabtree v. Goetz, No. 3:08-0939, filed in this District challenging changes to TennCare's home health benefits. Id. at Docket Entry No. 100 Third Interveners' Complaint. Based upon the ruling in that action[1], Crabtree v. Goetz,

---

[1]In Crabtree, the Court concluded that:

> The Court concludes that Plaintiffs' proof establishes that as persons with disabilities, the Defendants' new benefits cuts for home health services will cause their institutionalization into nursing homes. Here, the Defendants' cuts will eliminate services that enable Plaintiffs to remain in their community placement. The Defendants previously determined that Plaintiffs' community placement was medically necessary and was the least costly method to deliver such services. Plaintiffs' proof is that the Defendants are now forcing Plaintiffs into nursing homes without any mechanisms to determine whether their medical needs can be met in the community or the nursing home. Plaintiffs' physicians and other health care providers describe the Defendants' cuts as forcing these Plaintiffs into nursing homes that would be detrimental to their care, causing, inter alia, mental depression, and for some Plaintiffs, a shorter life expectancy or death. This categorical approach is to reduce the demand side of the community services market without any efforts to adjust the supply side of the home services market (where the MCOs are generating administrative costs that represent half of the Plaintiffs' health care costs), and without individual evaluations of Plaintiffs' actual medical needs.
>
> For these Plaintiffs, the isolating and deleterious effects described by the Supreme Court in Olmstead are present: loss of individual lives, community activities and separation from their communities and loved ones. Plaintiffs' treating physicians attest to these adverse effects if Plaintiffs' current home care services are so drastically cut. Moreover, as the Supreme Court stated: "[I]nstitutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of

No. 3:08-0939, 2008 WL 5330506, at **30-3 (M.D. Tenn. Dec. 19, 2008), TennCare continued Plaintiff's existing home health services until implementation of the Defendants' CHOICES program and completion of Plaintiff's individualized assessment thereunder. From June 19, 2008 until this action, Plaintiff received 24 hours of home medical treatment seven days a week. (Docket Entry No. 16, Dr. Willis Declaration at ¶¶ 5, 8). This care consisted of twelve hours per day for private duty nursing and twelve hours per day for home health aide care. Id. During this period, Plaintiff was under 21 years of age and his benefits were under the Defendants' plan for Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT"). Id. at ¶ 6. Plaintiff who is now over 21 years of age, is ineligible for EPSDT benefits. Id.

BlueCare, one of the Defendants' managed care organizations ("MCOs") that administer services for the Defendants' CHOICES program for adult care will determine his home health care benefits. Id. at ¶ ¶ 3, 5. In early 2012, BlueCare initiated its assessment of Plaintiff's medical needs and evaluated Plaintiff for community-based services through Tennessee's CHOICES program. (Docket Entry No. 15, Swiney Declaration at ¶ 3). Under TennCare benefit limits and the CHOICES program, qualified enrollees are not entitled to all medical services necessary to remain in their homes. BlueCare had to develop a plan for Plaintiff's medical care consistent with CHOICES's covered benefits. (Docket Entry No. 17, Killingsworth Declaration at ¶ 48). Plaintiff's mother who is also Plaintiff's conservator rejected BlueCare's various options for her

---

> participating in community life." Olmstead, 527 U.S. at 600. Reduced benefits are not based on a standard of adequate medical care, but solely on fiscal considerations.

2008 WL 5330506 at * 25. The Court also noted "[a] recent report" of "a CMS study [that] ranked Tennessee's nursing homes 47th among the States. The Tennessean, December 18, 2008 at p.1." Id. at 20 n.5.

son's medical care, including for hiring of a 24-hour live-in caregiver to assist with personal care and health care tasks and attendant care with 15 hours per day at an hourly rate of $10). (Docket Entry No.15, Swiney Decl., ¶¶ 12-18, 30, 34, 37). Defendants note that Plaintiff's mother was unreceptive to providing care for her son when paid care would be unavailable due to CHOICES cost limit. Id. at ¶ 17. Plaintiff's mother also rejected skilled nursing facility ("Level 2 NF") care rating for her son's placement in a nursing home and terminated the enrollment process. Yet, in February 2013, BlueCare performed two home visits, but Plaintiff's mother again rejected BlueCare's options for community services or nursing facility reimbursement through CHOICES program. Id. at ¶¶ 6-27.

On May 3, 2013, Dr. Mathew T. Kraus and Tina Williams, a registered nurse performed a "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for Plaintiff that reads, in pertinent part:

> "Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
>
> FR Private Duty Frequency: SN 84 and CNA 84 hours per week
> SN SN to administer medications via g-tube with 120ml H2O
> SN to administer feedings via g-tube Flush with 120 ml H2O
> Additional Interventions to include: SN to apply glasses PRN Q shift
> Additional Intervention to include: SN to apply eye patch to affected eye PRN for squinting of eyes or dilated pupil
> Additional Interventions to include: SN to cleanse nares PRN with BBG; to keep nasal airway passage clear

(Docket Entry No. 26-4 at 1). Plaintiff was rated as having functional limitations in six of the nine functional categories. Id.

Dr. Kraus, an internist and pediatrician who has been Plaintiff's primary care physician since Plaintiff was 5 years old, filed his declaration in this action that reiterates his earlier

findings, but adds that "[w]ithout the level of home health care he receives now [168 hours], it is my opinion, based on a reasonable medical certainty, that Jerry will be at great risk of further complications requiring hospitalization at greater expense than the home health care". (Docket Entry No. 4, Exhibit C at ¶ 6). Dr. Kraus also stated that with the Defendants' proposed care of 40 hours of home health services, Plaintiff will be forced to be placed in a nursing home. Id. at ¶¶ 5-7. Kraus is unaware of any medical study that a nursing home is an appropriate medical placement for a person with Plaintiff's condition. Id. In Dr. Kraus's opinion, Plaintiff needs a higher level of care than provided in a nursing home and additional staff would be necessary. Id. Dr. Kraus also stated that it is not safe for Mr. Wilborn to be left by himself because of his constant need for "secretion/pulmonary" care. Id.

Dr. Robert Chironna who specializes in rehabilitation medicine at the Patricia Neal Rehabilitation Center in Knoxville agrees with Dr. Kraus that Plaintiff cannot be alone because of his constant need for suctioning. (Docket No. 4, Exhibit D. At ¶ 3). In Dr. Chironna's opinion, Plaintiff 's condition is "complex enough that he requires frequent suctioning ... needs frequent position changes and multiple tube treatments and feedings Id. Given his condition, Dr. Chironna notes that Plaintiff id "unable to use his hands and cannot push a button" Id. at ¶ 4. Dr. Chironna shares Dr. Kraus's opinion that the Defendants' proposed offer of home services would require Plaintiff's placement in a nursing home and such placement creates a greater risks of hospitalization that would exceed the cost of his current home care regimen. Id. at ¶¶ 6-8. In a second affidavit, Dr. Chironna opines that Plaintiff's need for constant suctioning cannot be provided by the typical nursing facility and recommends a tracheotomy unless Plaintiff can receive constant suctioning. (Docket Entry No. 26-10 at 2-3).

Rena Yeary, a licensed practical nurse who has been one of Plaintiff's providers and prior to that worked in skill nursing facilities, submitted her affidavit on Plaintiff's medical needs and the likely effects of a nursing home placement. (Docket Entry No. 26-11 at ¶¶ 1-3). Yeary describes Plaintiff as a "silent aspirator" who does not evince any warnings or signs of his need to aspirate. Id. at ¶ 2. Because Plaintiff cannot be heard from another room, "he requires constant monitoring". Id. In Yeary's experience, a nurse in a long term care facility has 20 to 30 patients in addition to rounds and could not provide the requisite care for Plaintiff. Id. at ¶ 3.

Plaintiff notes that the Center for Medicaid and Medicare Services (CMS) collects data concerning nursing facility staffing and makes ratings available online at http://www.medicare.gov/NursingHomeCompare. Among six nursing facilities within 25 miles of Plaintiff's home in Morristown, the highest ranked facility for staffing averaged less than 5 staff hours (including RNs, LPNs, CNAs and PTs) per resident per day; the lowest averaged about 3.5 staff hours per resident per day. (Docket Entry No. 26-9 at ¶ 4). In Crabtree, the Court noted "[a] recent report" of "a CMS study [that] ranked Tennessee's nursing homes 47th among the States. The Tennessean, December 18, 2008 at p.1." 2008 WL 5330506 at * 20 n.5.

Dr. Andrea Willis, BlueCare's director for its CHOICES program, responds that BlueCare had never determined that Plaintiff needed 24/7 care that is not provided in any medical care setting. (Docket Entry No. 16 at ¶¶ 2-3). Dr. Willis stated that the care sought for Plaintiff "is simply not provided elsewhere – not in adult patient homes, nursing facilities, or routinely in hospital inpatient settings. Certainly, patients receive periodic episodes of hands-on, one-on-one care as needed. However, a nurse or aide is not assigned to a patient's bedside every hour of every day. Such care is prohibitively expensive and is more than is required". Id. at ¶ 23.

As to Plaintiff's need for additional nurses for his nursing home placement, Dr. Wiillis stated that those issues could be addressed during the admission process, and the nursing facility would provide the staffing and plan necessary to provide appropriate care for Plaintiff, but the reimbursement rate to the hospital for Plaintiff's care would remain the same. Id. at ¶ 21. The Defendants do not explain the economic viability of the nursing home agreeing to provide additional nurses without additional compensation or reimbursement.

By notice dated February 20, 2013, Blue Care informed Plaintiff that as of March 2, 2013, Plaintiff would receive only 40 hours of home health services and or placement in a nursing facility. (Docket No. 4, Exhibit A). BlueCare also notified Plaintiff that his current services of private duty nurse and home health aide would also end effective March 2, 2013. (Docket Entry No.16, Dr. Willis Declaration, Exhibit B thereto and Docket Entry No. 15, Swiney Declaration at ¶ 28). At some point, BlueCare offered Plaintiff 30 hours per week of home nursing services and 10 hours per week for a home health aide, the maximum benefits for adults with similar circumstances as Plaintiff. Id. Defendants also informed Plaintiff that he was eligible for 101.5 hours of care per week through the CHOICES program, but this limit created a 66.5 hour gap each week that Plaintiff's mother is unable to cover. Defendants contend those offered services actually exceed the applicable benefit limits for adults. Id. Tenn. Comp. R. & Regs. 1200-13-13-.01 (56).

Plaintiff appealed BlueCare's service reduction plan. (Docket Entry No. 15, Swiney Declaration, at ¶¶ 28-37). An Administrative Law Judge ("ALJ") determined Blue Care correctly terminated Plaintiff's daily twenty four hour services benefits, but also found that "Petitioner **cannot be left alone primarily due to his inability to swallow properly. Petitioner frequently**

chokes on hs saliva which must be cleared from his throat using a suction device" (Docket Entry No. 26-8 at 2) (emphasis added). The ALJ also found that **"Petitioner [Plaintiff] "requires 24 hours per day, 7 days per week of either PDN or HHA care to meet his medical needs."** Id. (emphasis added).

2. Defendants' CHOICES Program[2]

Tennessee's Long Term Care Community Choices Act authorizes the creation of a "long-term care system" that "shall promote independence, choice, dignity, and quality of life ... and shall include consumer-directed options that offer more choices regarding the kinds of long-term care services people need [and] shall offer services ... delaying or preventing the need for more expensive, institutional care." Long Term Care Community Choices Act of 2008, Pub. Ch. No. 1180, Senate Bill No. 4181, an Act to amend Tenn. Code Ann., Title 63, 68 and 71. This legislative goal promotes the purposes of the ADA and RHA.

A part of the State's "long term care system" is the Defendants' TennCare program that is authorized and funded by the United States in a ratio of $3 in federal funds to every $1 of state funds. Defendants note that Federal regulations on State waivers for home and community based medical care services require cost neutrality between the cost of community care and the institutional care, such as a nursing facility. Defendants assert that the Center for Medicare and Medicaid Services ('CMS") will not approve such a waiver request unless the State Medicaid

---

[2]The Court incorporates by reference its earlier outline of the history of the Defendants' TennCare benefits for home health care in Crabtree, that described Tennessee's statutory scheme for long-term home health care services. 2008 WL 5330506, at **16-23. Since the ruling in Crabtree, the Defendants adopted plans for long-term health care under its state laws and secured a Medicaid waiver.

agency provides specific assurances of cost neutrality of the waiver program. (Docket Entry No. 17, Killingsworth Declaration, at ¶ 18, n. 3, citing 42 C.F.R. § 441.302). According to Defendants, this cost neutrality mandate requires the State to ensure that the per capita cost of providing home and community based services and all other Medicaid services to enrollees in the HCBS Waiver program does not exceed the per capita cost of providing institutional care plus the cost of providing all other Medicaid services to institutionalized residents that are not included in the payment for the institutional care. Defendants cite 42 C.F.R. § 44.301(a)(3) as providing that a State's waiver application must specify whether cost neutrality will be determined on an aggregate basis (by combining the costs of waiver and other Medicaid services for all individuals enrolled in the waiver and comparing the average per capita cost to the average cost of institutional and other Medicaid services), or on an individual basis (by comparing such costs on an individual basis).

For its home and community based waiver, Tennessee has elected to calculate budget neutrality on an individual basis. (Docket No. 17, Killingsworth Declaration at ¶ 18, n. 3). Thus, the Defendants' CHOICES program imposes an individual cost neutrality cap, namely that the cost of services provided to an individual in the home and community cannot exceed the cost of care in a nursing facility for an individual. Id. at ¶ 18. Defendants cite this cost limitation as consistent with the State's statutory purpose and public policy to structure the program to maximize the number of enrollees. Id. at ¶¶ 37, 43.

As pertinent here, Tennessee's "CHOICES" program offers limited medical care, personal assistance care, and personal care service for community or home care with certain exceptions. Under CHOICES, the limit for home health care services is the cost of nursing

facility care- $55,000 per year for level 1 care nursing facility and $59,000 per year for level 2 care nursing facility. (Docket No. 17, ¶ 29). The exceptions are persons with tracheotomies who require "deep suctioning," for which the limit is $144,000 per year and a person who is ventilator dependent, the limit is $216,000 per year. (Docket No. 26 at 14).

CHOICES also has a "Consumer Direction" option that allows the enrollee to hire personnel to provide home and community-based services consistent with the cost limitations for the CHOICES program. Id. at ¶¶ 47- 48. [3] Persons who are unable to direct their own services are permitted to designate a Representative for Consumer Direction to employ workers and direct services on their behalf. Id. at ¶ 48. More than 1,000 CHOICES enrollees elected this Consumer Direction option. Id. CHOICES enrollees can select workers delivering services through Consumer Direction that a licensed or registered nurse provided at the direction of the enrollee or his authorized representative at less cost. Id.

To be accepted into CHOICES, an enrollee must accept the individual cost neutrality cap that, in effect, limits the available services to meet enrollee's health needs. If an individual needs services in excess of the "individual cost cap," Defendants' CHOICES's program and policy "allow" TennCare enrollees to "choose" medical care in an institution or go without long term services and supports. Plaintiff notes that these "individual cost caps" in the aggregate do not

---

[3] The services subject to Consumer Direction are personal care, attendant care, in-home respite care, and a community-based residential alternative to institutional care that is available only through Consumer Direction, called Companion Care. The Companion Care option affords the availability of a 24-hour live-in caregiver for persons who need assistance with activities of daily living at intervals throughout the day and night, but do not have family members or other natural supports to provide that assistance. Currently, there are 201 individuals receiving Consumer Directed Companion Care in CHOICES. (Docket Entry No. 17 Killingsworth Declaration at ¶ 47).

exceed expenditure projections for the CHOICES program given its current operation for which there is not a waiting list.

Aside from the CHOICES cost limitation and stated exceptions, TennCare's MCOs are permitted to provide an accommodation or a cost-effective alternative to institutional care, in excess of those limits, provided the total cost of home health and private duty nursing does not exceed the applicable level of nursing facility reimbursement the individual would otherwise qualify to receive. (Docket Entry No. 17, Killingsworth Declaration at ¶¶ 43-44).Yet, the central determinant in CHOICES is the individual cost neutrality cap, a requirement that the cost of services provided to an enrollee in the home and community cannot exceed the cost of care in an institution at a Level 1 or Level 2 nursing home reimbursement only. Id. at ¶ 18. A CHOICES enrollee can receive home care services that cost more than the average cost of Level 1 nursing home reimbursement. Id.

CHOICES's implementation commenced on March 1, 2010, with an enrollment target of 7,500 that was increased to 9,500 in September 2011, and ultimately to 12,500 on July 1, 2012, but there is not a waiting list.[4] Id. at ¶ 40. As of June 1, 2013, 12,417 individuals receive CHOICES HCBS as an alternative to nursing facility placement. Id. at ¶ 41. Over 500 individuals were transferred from nursing facilities to enrollment in CHOICES HCBS during the first year of the program's operation, and total nursing facility-to-community transitions in

[4] According to the Defendants, these enrollment targets represent the enrollment limit on CHOICES Group 2, enrollees who meet the medical eligibility requirements for nursing facility care, but who have elected to receive home or community care. Through December 31, 2013, there is no enrollment target on CHOICES Group 3 for enrollees who do not meet nursing facility level of care criteria, but are determined to be "at risk" of nursing facility placement unless home and community based services are available.(Docket Entry No. 17 Killingsworth Declaration at ¶ 40 n. 6).

CHOICES during the first two full program years exceeded 1,300. Id. at ¶¶ 50-56. TennCare MCOs are subject to specific contractual requirements relating to nursing facility diversion and transition. Id. at ¶¶ 52-55. In July 2012, the State raised the nursing facility level of care ("LOC" or medical eligibility) standard to target the nursing facility benefit to persons with higher acuity of need, but retained home and community based services to prevent or delay the need for nursing facility placement. Id. at ¶ 5. Within eight months after initiating the new LOC standards, the State has diverted almost 18% of all new nursing facility applicants (total numbers not provided) to more integrated community-based settings. Id. at ¶¶ 57-60.

As of June 30, 2012, 12,862 persons receiving HCBS under CHOICES had an average cost of $12,262 per person – over 50% less than the "individual cost cap" of $55,000 per person who qualifies for nursing facility care at level 1 and 39% less than the average per person nursing facility expenditure during FY 2012[5]. (Docket Entry No. 17-2, Exhibit B to Killingsworth Declaration). From February 2010 to June 30, 2012, the average per person HCBS expenditure decreased by $3,784 per person while the number of persons receiving HCBS increased by 6626 over the same period. Id. During that same period, the number of persons receiving nursing home care decreased by 4%, but the average cost per person for nursing home care caused expenditure to increase by 4%. Id. According to TennCare Director Darin Gordon, as of the end of FY 2012,

[5] Plaintiff contends that "[t]hese figures reveal two facts. The State's HCBS program is designed to capture "low-hanging fruit" – to cover individuals with the lowest cost of HCBS – at the expense of individuals with more complicated care requirements like Jeremy Wilborn. Increasing services for Mr. Wilborn to enable him to remain in his home and community will have no significant impact on the financial trends for HCBS but his placement in a level II or higher level NF will certainly continue the upward per member expenditures for nursing facility services." (Docket Entry No. 26, Plaintiff's Reply at 11-12).

the "[a]nnualized per member **expenditures for nursing facility services have increased by 6% from $42,300 in FY 2010 . . .**, while annualized per member HCBS expenditures have declined by 26% (from $21,100).(Docket Entry No. 26-7 at 1, Letter dated February 3, 2013 from Gordon to Sen. Ramsey and Rep. Harwell).

In 2012, more than 90% of TennCare's expenditures for long term care are for nursing home care. Id. Of the State's expenditures for long term medical care in 2012, nursing homes received $951,177,000 and home and community care received $157,682,800. Id. For 2013, the projected expenditures are $964,847, 900 for nursing homes and for the home and community care $180, 567,900. Id. Nursing home costs rose by 6% in fiscal year 2012, but home health care costs declined by 26% Id. at 2.

Defendants estimate that the cost of 24/7 private duty nurse services to a single enrollee exceeds $324,000 and if required, would limit CHOICES enrollment to no more than 20 individuals. (Docket Entry No. 17, Killingsworth Declaration at ¶ 13) Defendants estimate the annual cost of Plaintiff's current home services at $238,320 that would limit CHOICES HCBS to just over 15 individuals. Id. As discussed infra, the relevant analysis is the cost of providing care to comparable individuals. On its face, the Defendants' costs projections analysis fail to limit their analysis to the enrollees with medical needs comparable to Plaintiff's needs.

B. **Conclusions of Law**

Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a) is "commonly-known as the civil rights bill of the disabled," Americans Disabled for Accessible Public Transportation (ADAPT) v. Skinner, 881 F.2d 1184, 1187 (3rd Cir. 1989) (en banc). The RA prohibits disability-based discrimination by federally funded recipients:

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

29 U.S.C. § 794(a).

Extending the prohibitions of Section 504, Congress enacted the Americans with Disabilities Act (ADA) in 1990, to prohibit discrimination by all public entities, regardless of whether they receive federal funding. 42 U.S.C. §§ 12131-12165; H.R. Rep. No. 101-485, pt. 3, at 49 (1990), reprinted in 1990 U.S.C.C.A.N. 267, 472. The goals of the ADA "are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for each individual [with disabilities]." 42 U.S.C. § 12101(a)(7). The ADA and Section 504 are analyzed together because there is no significant difference in the analysis of rights and obligations created by the two. Radaszewski v. Maram, 383 F.3d 599, 607 (7th Cir. 2004); Fisher v. Oklahoma Health Care Authority, 335 F.3d 1175, 1179 n.3 (10th Cir. 2003).

In enacting the ADA, Congress made certain findings: "(2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem; (3) discrimination against individuals with disabilities persists in such critical areas as ... institutionalization ... (5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, ... failure to make modifications to existing facilities and practices, ... [and] segregation ... " 42 U.S C §§ 12101(a)(2), (3), (5). In the ADA, Congress declared that "segregation" of persons with disabilities is a "for[m] of discrimination," and that such discrimination persists in the area of

"institutionalization" 42 U S..C §§ 1210l(a)(2), (3), (5).

The ADA expressly applies to "any State or local government". 42 U. S. C §§ 12131(1)(A), (B). The ADA prohibits denial of "the benefits of the services, programs, or activities of a public entity, or [to] be subjected to discrimination by any such entity.." 42 U. S.C. § 12132. A regulation implementing the ADA specifically requires public entities to make reasonable modifications in "policies, practices, or procedures" when the modifications are necessary to avoid discrimination, unless the accommodation would fundamentally alter the nature of the program. 28 C. F. R. § 35.130(b)(7). Section 504 of the RA also requires publicly-funded programs to provide reasonable accommodations when needed to assure that persons with disabilities have meaningful access to such programs and services. 29 U.S.C. § 794(a); see also Southeastern Community College v. Davis, 442 U.S. 397, 410 (1979).

Under the ADA, a "qualified individual with a disability" is a person who "with or without reasonable modifications to rules, policies or practices" meets the "essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2). Section 504's definition is substantially similar. See 29 U.S.C. § 705(2)(B). ADA regulations define disabilities, with respect to an individual, to include "a physical or mental impairment that substantially limits one or more of the major life activities of such individual ... such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 28 C.F.R. §§ 35.104. The Section 504 requirements are essentially the same. 28 C.F.R. § 41.31. The Court concludes that Plaintiff's quadriplegia renders him a qualified person with a disability within the meaning of the ADA and the RA.

The concept of "discrimination" under Section 504 and the ADA encompasses more than disparate treatment of people with disabilities as compared to non-disabled individuals. Olmstead v. L.C., 527 U.S. 581, 598 (1999) (ADA); Alexander v. Choate, 469 U.S. 287, 300-01, (1984) (Section 504). In addition to Congress's finding that segregation of persons with disabilities, especially in institutions, is a form of discrimination, 42 U.S.C. § 12101(a)(2), (3), (5), the Supreme Court has also held that unjustified isolation is properly regarded as discrimination based on disability under the ADA. Olmstead, 527 U.S. at 597. Such institutionalization of individuals with disabilities who can live in the community "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Id. at 600. Moreover, institutional confinement "severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Id. at 601. Thus, a State is obligated to provide community-based treatment for disabled persons if; (1) the state's treatment professionals find that community-based treatment is appropriate; (2) the affected individuals do not oppose community-based treatment; and (3) placement in the community can be reasonably accommodated, taking into account the state's resources and the needs of others with similar disabilities. See Olmstead, 527 U.S. at 607; Radaszewski, 383 F.3d at 608 ("In view of the integration mandate, the [Olmstead] Court agreed ... that a State is obliged to provide community-based treatment for individuals with disabilities ...."). Section 504's ban on disability discrimination also encompasses unjustified institutionalization. See, e.g., Frederick L. v. Dep't of Public Welfare, 157 F. Supp. 2d 509, 538 (E.D.Pa. 2001). To be sure, in Olmstead, the Supreme Court noted that "[w]e do not in this opinion hold . . . that the ADA

requires States to 'provide a certain level of benefits to individuals with disabilities' . . . .." 527 U.S. at 603 n.14.

The ADA designated the Attorney General to promulgate regulations to enforce the ADA. Among those regulations is the "integration mandate regulation," that provides: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.." 28 C. F. R. § 35.130(d) (1998). The preamble to these regulations defines "the most integrated setting appropriate to the needs of qualified individuals with disabilities" as, "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible " 28 C. F. R. § 35, App A, at. 450 (1998). Under RA regulations, agencies receiving federal financial assistance must administer their programs and activities "in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 C. F. R. §41.51(d) Moreover, the ADA regulations provide that:

> A public entity shall make reasonable modifications in policies, practices, 01 procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.."

28 C. F. R. § 35.130(b)(7) (1998). The ADA's implementing regulations also prohibit arrangements that have a discriminatory effect. Under this ADA regulation, a public entity may not:

> directly or through contractual or other arrangements, utilize methods of administration (I) [t]hat have the effect of subjecting qualified individuals with a disability to discrimination on the basis of disability; [and] (ii) [t]hat have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with

disability.

28 C.F.R. § 35.130(b)(3). Section 504 regulations contain similar requirements. See 28 C.F.R. § 41.51(b)(3)(I); 45 C.F.R. § 84.4(b)(4). These regulations, known as the "integration mandate," are construed and applied in the same manner. Fisher, 335 F.3d at 1179 n. 3.

The United States Supreme Court analyzed and interpreted the integration mandate in Olmstead, involving individuals with mental disabilities who were confined in Georgia's state psychiatric institutions, but who wanted to live in the community. 527 U.S. at 587. The Olmstead plaintiffs asserted that the state's refusal to pay for services that would enable them to live in community settings violated the integration mandate of Title II of the ADA and its implementing regulations. Id. The Supreme Court agreed, and held that "unjustified isolation ... is properly regarded as discrimination based on disability." Id. at 597. The Supreme Court did not agree on the precise standard to determine when institutionalization is unjustified. A plurality in Olmstead, articulated a standard that lower courts have since applied: states should be required to place persons with disabilities in community settings rather than in institutions when the state's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities. Id. at 587. The plurality, however, stated that an accommodation is unnecessary, if the state can demonstrate that the modifications would fundamentally alter the nature of the services, program, or activity. Id., citing 28 C.F.R. § 35.130(b)(7).

As these principles are applied here, albeit under the aegis of another TennCare program, the Defendants previously determined that Plaintiff needed these medical services provided at his home. Plaintiff's prior placement in a nursing home resulted in the nursing home's decision to release Plaintiff due to the demands of his medical care. Plaintiff's treating physician recently determined that Plaintiff needs his medical services in his home. Such facts have been deemed sufficient for injunctive relief See, e.g., Radaszewski, 383 F.3d at 608 (holding that there was "little doubt" that the plaintiff could be cared for at home because he had been receiving care at home for more than 10 years). With the Defendants' cost limits for home care, Plaintiff would be forced to move to a nursing facility. Based upon these facts, the Court concludes that the Defendants have not provided Plaintiff, a qualified person with a disability, with a reasonable accommodation with its CHOICES cost limits that would in effect, cause the institutionalization of the Plaintiff, contrary to the ADA and RA.

The Defendants argue that Plaintiff's motion seeks an unreasonable accommodation because the Defendants have offered benefits for home care that are equal to the nursing home care level to which Plaintiff was rated. Based on these cost factors, Defendants argue that Plaintiff's requested accommodation exceeds the relief awarded under the integration mandate, citing Olmstead, 527 U.S. at 604 (recognizing the lower court determination that the community placements requested by the plaintiffs cost less than institutional care); Fisher v. Okla. Health Care Auth., 335 F.3d 1175, 1183 (noting that the cost of institutional care for the plaintiffs would be "approximately twice as high as community-based care"); Radaszewski ex rel. Radaszewski v. Maram, No. 01-C9551, 2008 WL 2097382, at *15 (N.D. Ill. 2008) (finding that the "unrebutted evidence clearly shows that the cost of caring for [plaintiff] in the proper institutional setting . . .

would be substantially greater than the cost of allowing [him] to remain in the community") and Crabtree, 2008 WL 5330506, at **2, 22 ("**that the costs of nursing home care exceed the costs of their necessary home health services**, and that under state law, the cost of the nursing home care can be made available to them to pay for such services in their home...Of particular significance [the CHOICES program] authorizes the Plaintiffs to receive TennCare funding to effect their own home health care plan, including the hiring of a family member or friend at their residence or in a community setting."). In sum, the Defendants argue that the State has offered Plaintiff the relief that he requested in Crabtree.

As to these contentions, at the time of Crabtree, the Defendants' current plan for community services was not sufficiently defined under the Olmstead analysis. The Court observes that at the time of the Crabtree decision, the Defendants had not provided any individual health assessments for adults nor implemented the State statute's CHOICES program for adult home health services. The alternative costs in Crabtree were identified by the plaintiffs as sufficient for their home medical service needs. Here, based upon the 2013 individualized assessment of Plaintiff's medical needs, Plaintiff's treating physician prescribed the home care regimen of twenty four hours/seven days a week care with a combination of nurse and home health aide. At the hearing, Plaintiff identified a self directed plan for his care at a cost of $108,137 (Docket Entry No. 37) that is much less than the Defendants' assertions of those costs and consistent with the Defendants' cost cap for similarly situated CHOICE enrollees.

Contrary to the Defendants' assertions, the Court is not taking Plaintiff's cost contention "to its logical extremes" so as to "require state Medicaid programs to reproduce every care environment found in the overall health continuum within an enrollee's home, if the enrollee

preferred that community setting, regardless of cost." (Docket Entry No. 13, Defendants' Memorandum at 26). The Defendants' chosen measure of costs based upon nursing home care may be presumptively adequate, given CMS's approval. Yet, the ADA and the RA stand independent of the Medicaid statute and simply require consideration of an individual enrollee's medical needs and the impact of providing such needs for similarly situated enrollees. As the Attorney General's Statement on Olmstead and the ADA observes: "A state's obligation under the ADA are independent from the requirement of the Medicaid program...the Medicaid Act does not exempt the state from serving additional people in the community to comply with the ADA or other laws, for example by seeking a modification of the waiver to remove the cap". (Docket Entry No. 26-5 at 5). Here, the relief ordered by the Court is within the cost parameters of the Defendants' cost limitation for similarly situated TennCare enrollees.

For an award of preliminary injunctive relief, the Court must consider four factors: (1) likelihood of Plaintiffs' success on the merits; (2) any irreparable harm to the Plaintiffs; (3) any adverse effect on other parties or persons; and (4) the public interest. Gonzales v. National Bd. of Med. Exam'rs, 225 F.3d 620, 632 (6th Cir.2000). Based upon the Court's findings, the Defendants' failure to provide services "in the most integrated setting appropriate," or placing a qualified individual at "high risk for premature entry into a nursing home," satisfies the standard for granting injunctive relief under the ADA and RHA. See Fisher v. Oklahoma Health Care Authority, 335 F.3d 1175, 1184-1185 (10th Cir. 2003).

The loss of necessary Medicaid services constitutes irreparable harm. See Daniels v. Wadley, 926 F. Supp. 1305, 1313 (M.D. Tenn. 1996) vacated in part on other grounds sub nom Daniels v. Menke, 145 F.3d 1330 (6th Cir. 1998); Markva v. Haveman, 168 F. Supp. 2d 695,

719 (E.D. Mich. 2001) (recognizing that there is no adequate remedy at law for denial of medical care and recognizing "the principle that denial or delay in benefits which effectively prevents plaintiffs from obtaining needed medical care constitutes irreparable harm. In other words, risk of further injury to health warrants injunctive relief."). See also, e.g., Maine Ass'n of Interdependent Neighborhoods v. Petit, 647 F. Supp. 1312, 1315 (D. Me. 1985) (holding that forcing plaintiff to leave her family and enter a nursing home would irreparably injure her physical and mental health); Kai v. Ross, 336 F.3d 650, 656 (8th Cir. 2003); Beltran v. Meyers, 677 F.2d 1317, 1322 (9th Cir. 1982) (holding that irreparable injury shown when enforcement of a Medicaid rule "may deny [plaintiffs] needed medical care); Caldwell v. Blum, 621 F.2d 491, 498 (2d Cir. 1980) (holding that Medicaid applicants established harm where they would "absent relief, be exposed to the hardship of being denied essential medical benefits"); McMillan v. McCrimon, 807 F. Supp. 475, 479 (C.D. Ill. 1992) (holding that "[t]he nature of their claim - a claim against the state for medical services- makes it impossible to say that any remedy at law could compensate them").

The public interest is served by the enforcement of the ADA and the RHA, as found by other courts. See, Fisher, 335 F.3d at 1180; Heather K. v. Mallard, 887 F. Supp. 1249, 1260 (N. D. Iowa 1995).

The Court concludes that Plaintiff, as a person with a serious and permanent disability, will suffer severe harm, if he is confined at a nursing home instead of receiving medical services in his home. Plaintiff lacks the financial resources to pay for his in-home health care out of pocket. Plaintiff's mother is unable to cover the gap in coverage created by the Defendants' cost limitations. Given the medical complexity of Plaintiff's condition, Plaintiff is unable to receive

adequate care in a nursing home because the nursing home is likely unable to assume the individual health care attention Plaintiff requires. In addition to Plaintiffs' physicians, the ALJ found that Plaintiff needed 24/7 medical care. Nurse Yeary provides insightful information about the 20-30 patient assignment for a nurse in a skilled nursing facility. Killingsworth's affidavit admits that the level of care earlier provided to and sought by Plaintiff is cost prohibitive and is unavailable in any medical care setting. Although Defendants refer to the prospect of discussions with the nursing home about additional staff for Plaintiff, the Defendants also state that the nursing home's reimbursement rate would remain the same. The Court is unclear if this stated option is realistic from the perspective of a nursing home. Absent such care, Plaintiff's physicians opine that placement of Plaintiff in a nursing home would pose serious risk to Plaintiff's health and creates serious risk of more expensive hospitalization without proper care. As the Court noted in Crabtree, CMS rated Tennessee's nursing care 47th out of all 50 States. Defendants' cost limitations will force Plaintiff into a nursing facility that is not a reasonable accommodation and would endanger Plaintiff's life, for which any monetary award is inadequate. See McCrimon, 807 F. Supp. at 479.

As to the harm to others, the limited relief sought by the Plaintiff, approximately $108,137 in consumer directed care that is consistent with the CHOICES provisions for similarly situated enrollees, namely the enrollees with tracheotomies or who are ventilator dependent, where the high end of range of permissible cots is $216,000. These costs ranges are not shown to harm others as the Defendants do not dispute that their expenditures in the CHOICES program have not exceeded this program's budget. Finally, the Defendant cannot be harmed by complying with what the Federal law requires. As stated by the Seventh Circuit:

> Because the defendants are required to comply with the [law in question], we do not see how enforcing compliance imposes any burden on them. The Act itself imposes the burden; this injunction merely seeks to prevent the defendants from shirking their responsibilities under it.

Haskins v. Stanton, 794 F.2d 1273, 1277 (7th Cir. 1986) (granting injunction requiring defendant's compliance with Federal Food Stamp law.)

For the reasons stated above, the Court concludes that Plaintiff has demonstrated a strong likelihood of success on the merits of his ADA and RA claims that the Defendants' limits on his home health care services will force his institutionalization in a nursing home in violation of those Acts. The Defendants' prior approval of Plaintiff's home health care services and his treating physicians' assessment that Plaintiff continues to need such care are proof that institutionalization will cause injury to Plaintiff's mental and physical health demonstrating irreparable injury. For these reasons, the Court concludes that the Plaintiffs' motion for a preliminary injunction should be granted, but only if Defendants' fundamental alteration defense under ADA regulation for state programs lacks merit.

B. Defendants' Fundamental Alteration Defense

Defendants assert the fundamental alteration defense under the ADA regulation, 28 C.F.R. § 35.130(b)(7) as a bar to the relief sought by Plaintiff. In Olmstead, the Supreme Court described this defense:

> 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.

527 U.S. at 604.

Here, this controversy involves a single Plaintiff whose costs for his home care services represent only a fraction of the Defendants' total funds in its CHOICES program. Yet, for this defense, the Court must compare the impact of such relief to the cost of such relief to other similarly situated enrollees: "If the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State's entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. Id. at 603. Thus, where:

> the District Court compared the cost of caring for the plaintiffs in a community-based setting with the cost of caring for them in an institution ... a comparison so simple overlooks costs the State cannot avoid; most notably, a "State ... may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions."

Id. at 604.

On the other hand, as stated by the Tenth Circuit in Fisher: "[i]f every alteration in a program or service that required the outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed." 335 F.3d at 1183. The Third Circuit held that "states cannot sustain a fundamental-alteration defense based solely upon the conclusory invocation of vaguely-defined fiscal constraints." Frederick L., 364 F.3d at 496 (citing Makin, 114 F. Supp.2d at 1034). In Makin, Hawaii invoked the fundamental-alteration defense, contending that increasing community placements would violate state and federal funding limits and change its existing programs with "unlimited" state funding for community mental health services. 114 F. Supp.2d at 1034. The district court rejected that defense, reasoning that a potential funding problem, without more, would not establish the fundamental-alteration defense. Id.

As the Third Circuit explained in Frederick L., " Olmstead lists several factors that are relevant to the fundamental-alteration defense, including but not limited to the [1] State's ability to continue meeting the needs of other institutionalized mental health patients for whom community placement is not appropriate, [2] whether the State has a waiting list for community placements, and [3] whether the state has developed a comprehensive plan to move eligible patients into community care settings." 364 F.3d at 495 (citing Olmstead, 527 U.S. at 605-06). The cost comparison for this defense is the costs to provide the relief to substantially similar enrollees receiving home health care. In Radaszewski, where the plaintiff was a minor who required 24/7 coverage at a cost of $15,000 to $20,000 month for home medical care, the Seventh Circuit defined the appropriate cost comparison:

> **A court must therefore take care to consider the cost of a plaintiff's care not in isolation, but in the context of the care it must provide to all individuals with disabilities comparable to those of the plaintiff ... with similar needs** ... If the State would have to pay a private facility to care for Eric, for example, and the cost of that placement equaled or exceeded the cost of caring for him at home, then it would be difficult to see how requiring the State to pay for at-home care would amount to an unreasonable, fundamental alteration of its programs and services.

383 F.3d at 614 (emphasis added).

As to the first Olmstead factor, given Plaintiff's serious issues with his constant inability to swallow, the similar enrollees for costs comparison are CHOICES enrollees who are ventilation dependent or enrollees with tracheotomies whose cost caps or limitations are $144,000 to $214,000, respectively. Plaintiff identified the ability to meet his needs for home medical care at $108,137 (Docket Entry No. 37) that falls well under the Defendants' cost limit for similarly situated CHOICE enrollees. The Defendants have not shown that the expenditures

of home health services for similarly situated TennCare enrollees would force the placement of similarly disabled enrollees in nursing homes. Again, Defendants did not dispute that the funding for their CHOICES program is well within its budget, and that CHOICES does not have a waiting list.

As to the second factor, Plaintiff's proof is that within the structure of CHOICES, such services can be provided in combination with other TennCare services. Defendants allow Blue Care to make cost modification for a CHOICE enrollee consistent with cost caps; that is what Plaintiff has done in this action

The third factor under Olmstead is "whether the State has developed a comprehensive plan to move eligible patients into community care settings," Frederick L., 364 F.3d at 495 (citing Olmstead, 527 U.S. at 605-06). The Olmstead plurality provided a specific example of the limited reach of this integration mandate:

> If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with .... disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.

Id. at 498 (quoting 527 U.S. at 584) (emphasis added).

For this integration factor, a state must show that the plan "demonstrates a reasonably specific and measurable commitment to deinstitutionalization for which [it] may be held accountable." Frederick L., 422 F.3d at 157. As examples of a comprehensive working plan, in Sanchez v. Johnson, 416 F.3d 1051 (9th Cir. 2005), the Ninth Circuit found an effectively working plan where: (1) a 30 year old state law required coverage of services for people with developmental disabilities to prevent or minimize institutionalization; (2) a significant decrease

in institutionalized individuals occurred over a decade; (3) the State significantly increased community based spending, home and community based waiver slots over the course of a decade; (4) the State had a system of individualized community placement plans with extensive databases containing disabled citizens in the system. Id. at 1064-66. In Arc of Washington v. Braddock, 427 F.3d 615, 621 (9th Cir. 2005), the State's home care waiver program had increased home placements by more that 600 percent, the State doubled the budget for community-based programs, and had a 20 percent reduction in its institutionalized population. In Frederick L., the Third Circuit rejected Pennsylvania's deinstitutionalization plan for lack of time frames for patients' discharge from institutions, the lack of criteria of eligibility for discharge as well as the absence of defined arrangements with local authorities for housing, transportation, care and education to effectuate the disabled person's integration into the community. 422 F.3d at 160.

The Court first concludes that Tennessee Long Term Care Community Choices Act promotes the purposes of the ADA and RA. That Act states that "[t]he long-term care system shall promote independence, choice, dignity, and quality of life ... and shall include consumer-directed options that offer more choices regarding the kinds of long-term care services people need [and] shall offer services ... delaying or preventing the need for more expensive, institutional care." Long Term Care Community Choices Act of 2008, Publ. Chap. No. 1180, Senate Bill No. 4181, an Act to amend Tenn. Code Ann., Title 63, 68 and 71. Since Crabtree, the Defendants have implemented and CMS has approved CHOICES as a program for long-term medical services.

Yet, Plaintiff challenges Defendants' administration of the CHOICES program as

violating the ADA in that:

1. Defendants do not allow any exceptions to CHOICE cost caps;

2. Defendants deny enrollees the opportunity for individualized reasonable accommodations;

3. Defendants' inflexibility compels institutionalization to receive necessary medical services;

4. Defendants fail to provide a procedure which Plaintiff may obtain exceptions to cap and;

5. Defendants impose cuts in services without regard to the enrollee's individual needs.

Plaintiff further asserts that for contracts for home health or community based services and nursing facility care, Defendants pay its MCOs a "per capita" fee based on the number of people in the Medicaid program, regardless of what services individual patients receive. Plaintiff alleges that TennCare also pays extra fees to the nursing facilities, because nursing facility care is paid on a fee for service basis. This is not a class action and the proof submitted here is insufficient to assess these systemic challenges to the Defendants' CHOICES program.

Yet, despite the laudable State Act on long term care and the initial implementation of CHOICES with references to transition of enrollees from nursing homes to community based medical service, the Defendants' financial expenditures for 2012 and projected 2013 for long term health care reflect that more than 90% of the Federal and State funds are expended on nursing homes. These facts here reveal improvement from the facts in Crabtree:

> A comparison of the expenditures on the State's waiver plans from 2002 and 2007, based upon CMS data reveals the following:

	2002	2007
Aged/ Disabled	$6,102,958	$16,051,823
Developmentally Disabled	$261,603,425	$588,568,195

Nursing Homes	$936,533,890	$1,182,654,826

Plaintiffs' Exhibit No. 25. In a report issued in December, 2003, John Morgan, the State Treasurer issued a Report on "Serving the Aged and Disabled: Progress and Issues" and found among other things, that "[t]he state has not served any clients through the 1915(c) home and community-based services program, even though the Centers for Medicaid and Medicare (CMS) approved Tennessee's application in May 2002" (Plaintiffs' Exhibit No. 33, at p. I)

2008 WL 5330560 at *18.

To evaluate the facts here for the fundamental alteration defense, two Court of Appeals decisions are instructive. In Fisher, the state imposed a rule limiting Medicaid coverage of prescription drugs to only five prescriptions per month for individuals who were living in the community. 335 F.3d at 1178. If Medicaid beneficiaries required more than five prescriptions, they had to move into nursing homes, where prescriptions were covered without limits. Id. Plaintiffs requested an accommodation that would enable them to obtain prescriptions in excess of the five-prescription cap while still receiving the care in their homes. Id. The Tenth Circuit reversed a grant of summary judgment in defendants' favor and held that the cap on prescriptions could violate the ADA's integration mandate. Id. The Tenth Circuit rejected the district court's holding that fiscal burdens associated with reasonable accommodations would necessarily require a fundamental alteration, stating:

> [It is not] clear why the preservation of a program as it has existed for years . . . would fundamentally alter the nature of the program . . . Plaintiffs are simply asking that a service for which they would be eligible under an existing state program . . . be provided in a community-based setting rather than a nursing home. . . . Given that Oklahoma has, until recently, provided unlimited prescriptions to participants in the Advantage program, and continues to do so for those living in nursing homes, receiving medically necessary prescriptions is clearly in the nature of Oklahoma's HCBS program.

Id. at 1183.

With regard to financial burdens, the Tenth Circuit observed that "Congress was clearly aware that 'while the integration of people with disabilities will sometimes involve substantial short term burdens, financial and administrative, the long range effects will benefit society as a whole.'" Id. at 1183, quoting H.R. Rep. No. 101-485, pt. 3, at 50, reprinted in 1990 U.S.C.C.A.N. 445, 473. Moreover, the Tenth Circuit questioned whether the required accommodation would constitute a fiscal burden at all. In response to the lower court's suggestion that having to provide prescriptions in excess of the cap would force them to eliminate the home-based program altogether, the court observed that

> [g]iven that the cost of institutional care is nearly twice of community-based care, it seems unlikely that ... elimination of the waiver program, would have solved Oklahoma's fiscal crisis, because it could have served only to drive participants into nursing homes.

Id. at 1183.

In Radaszewski, the plaintiff had brain cancer and suffered a stroke at the age of 13 for which the plaintiff required twenty four hour care, with 16 hours per day of private duty nursing, to survive. 383 F.3d at 600-01. As here, when the plaintiff was under 21, his services were covered through a Medicaid program for children, but when he reached 21, the plaintiff was ineligible for continued coverage of those medical services under the state's program. Id. at 602. The State's community-based services for individuals over the age of 21 was capped at a funding level that would not provide 16 hours of nursing services and would have forced plaintiff to enter an institution to receive necessary care. Id. at 603. There, the plaintiff asserted claims for violations of the ADA and Section 504's integration mandate, but the district court granted the defendants' motion for judgment on the pleadings. The Seventh Circuit reversed and remanded for further findings, holding that "[t]he integration mandate may well require the state to make

reasonable modifications to the form of existing services in order to adapt them to community-integrated settings." Id. at 611.

On remand, the district court held that the state's failure to fund at-home, private duty nursing for the plaintiff was disability discrimination and ordered the state to pay for the sixteen hours of nursing services in his home. Radaszewslci v. Maram, No. 01-C9551, 2008 WL 2097382 (N.D. Ill. 2008) (Ex. A, hereto). Although the state's program for adults did not provide for coverage of these nursing services, the district court held that home and community-based services was a reasonable accommodation and rejected the state's fundamental alteration defense holding that the Plaintiff's nursing needs could be accommodated by approval of additional hours for nursing services, modifying or altering other Medicaid programs that covered nursing services, or pursuing amendments to the state's program g with the federal agency to promote community-based integration. Id. at *15. To be sure, the court also noted that the cost of providing care in "the proper institutional setting - a hospital - would be substantially greater than the cost of allowing (plaintiff] to remain in the community and receive the same proper treatment and community care." Id.

As stated in the Attorney General's policy statement on the ADA, a role assigned by Congress, to assert the fundamental alteration defense, "a public entity cannot rely on its Olmstead plan as part of its defense unless it can prove that its plan comprehensively and effectively addresses the needless segregation of the group at issue in the case". (Docket Entry No. 26-5 at 7) A public entity that cannot show it has and is implementing a working plan will not be able to prove that it is already making sufficient progress in complying with the integration mandate and that the requested relief would so disrupt the implementation of the plan

as to cause a fundamental alteration. See Day v. District of Columbia, 894 F. Supp.2d 1, 27 (D.C. 2012. ("A public entity cannot rely on its Olmstead plan as part of its defense unless it can prove that the plan comprehensively and effectively addresses the needless segregation of the group at issue in the case.").

Here, given the highly disproportionate share of Federal and State expenditures, 90% for nursing home care in contrast to 10% for community based home care, the Court cannot conclude at this time that the Defendants' have an effective Olmstead plan sufficient to bar Plaintiff's ADA and RA claims. Moreover, the very limited relief sought here does not implicate the fundamental alteration defense. As reflected in the Attorney General's statement on the ADA , "[p]roviding services beyond what a state currently provides under Medicaid may not cause a fundamental alternation." and provided the following example:

> For example, the fact that a state is permitted to "cap" the number of individuals it serves in a particular waiver program under the Medicaid Act does not exempt the state from serving additional people in the community to comply with the ADA or other laws, for example by seeking a modification of the waiver to remove the cap.

(Docket Entry No. 26-5 at 5).

Defendants contend that their MCOs can provide a reasonable modification of a home care plan, but only "so long as it is cost-effective." See Tenn. Comp. R. & Regs. 1200-13-13-.01(29), 1200-13-13-.04(1)(d) and 1200-13-13-.04(2). Defendants also cite the option for Plaintiff to "self-direct certain health care tasks that would otherwise have to be performed by a licensed or registered nurse", as an accommodation. (Docket Entry No. 17, Killingsworth Declaration at 21). Again, this "accommodation" is for any individual participating in the CHOICES program. Id. With the stated limitation of cost effectiveness within the cost

cap, the Court does not deem this option to be an accommodation within the meaning of the ADA, See Day v. District of Columbia, 894 F. Supp.2d at 26, ("an Olmstead Plan should do more than provide vague assurances of future integrated options or describe the entity's general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities.") (citing DOJ Statement at 6). According to the Attorney General 's statement on accommodations: "Remedies should [ ] focus on expanding the services and supports necessary for individuals' successful community tenure." (Docket Entry No. 26-5 at 8). The Defendants' proffered options do not extend to providing the necessary relief.

For these collective reasons, the Court concludes that Plaintiff's motion for a preliminary injunction should be granted as to his proposed plan for his home care needs that are consistent with the provisions for similarly situated enrollees in the Defendants' CHOICES program. (See Docket Entry No. 37). Plaintiff's proposed plan shall be implemented consistent with the CHOICES's procedures.

An appropriate Order is filed herewith.

Entered this the 15th day of August, 2013.

William J. Haynes, Jr.
Chief Judge
United States District Court

Exhibit 4. *Wilborn v. Martin*, Memorandum of Law dated February 18, 2014

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

JEREMY WILBORN, By Next Friend and Conservator, TARA WILBORN, Plaintiff, v. LARRY MARTIN, Commissioner, Tennessee Department of Finance and Administration; DARIN GORDON, Deputy Commissioner and Director, Bureau of TennCare; and PATTI KILLINGSWORTH, Assistant Commissioner, Chief of Long-Term Care, Bureau of TennCare, Defendants.	)	No. 3:13-cv-00574 Chief District Judge Haynes

MEMORANDUM OF LAW IN SUPPORT OF JOINT MOTION FOR INDICATIVE RULING TO EFFECT TERMS OF SETTLEMENT

This case is pending before the Sixth Circuit Court of Appeals on the Defendants' appeal from a memorandum and orders granting Plaintiff's motion for preliminary injunctive relief. The parties have reached a settlement agreement, subject to this Court's willingness to take certain actions. The parties therefore have filed a joint motion for an indicative ruling that the Court will accept a limited remand from the Court of Appeals and proceed with the requested actions. As described more fully below, the requested actions are necessary to effectuate the settlement of Plaintiff's claims and ultimate dismissal of the Defendants' appeal.

BACKGROUND RELEVANT TO MOTION

Plaintiff initiated this action on June 13, 2013, alleging that the State was in violation of the Americans with Disabilities Act and the Rehabilitation Act in its provision of TennCare services to him. Plaintiff also sought a preliminary injunction preventing the State from reducing his in-home services. The preliminary injunction motion was heard on July 12, 2013. During the hearing, Plaintiff proposed an alternative plan for his in-home care (Doc. No. 34). The Court granted preliminary injunctive relief to Plaintiff as to the proposed plan (Doc. Nos. 37, 40 and 41).

On August 16, 2013, the Defendants appealed to the Sixth Circuit Court of Appeals the Court's memorandum and orders granting Plaintiff's motion for preliminary injunctive relief (Doc. No. 42). In accordance with Rule 33 of the Sixth Circuit Rules, the Defendants and Plaintiff participated in mediation conferences from September 2013 through December 2013, and the briefing schedule for the appeal was extended. The parties reached an agreement that satisfies Plaintiff's claims in this case and provides a plan consistent with the Defendants' CHOICES program for meeting Plaintiff's medical care needs in the community and no less than preliminary injunctive relief.

Pursuant to the parties' settlement agreement, and subject to Plaintiff's enrollment in CHOICES in accordance with the agreement, Plaintiff agreed to dismiss his complaint and all pending claims in this case without prejudice, and the Defendants agreed to dismiss their appeal upon vacatur of the memorandum and

orders from which they had appealed and dismissal of Plaintiff's claims. The parties agreed to jointly file the papers necessary to obtain vacatur of the memorandum and orders, dismissal of Plaintiff's complaint, and dismissal of the appeal.

JOINT MOTION FOR INDICATIVE RULING

The parties' settlement of the appeal is subject to this Court's willingness to vacate the memorandum and orders from which the appeal was taken and to dismiss Plaintiff's complaint. Rule 62.1 of the Federal Rules of Civil Procedure provides the mechanism by which parties to an appeal may obtain an indicative ruling from the district court of the court's willingness, upon remand, to proceed with requested actions. Therefore, the parties have filed a joint motion for an indicative ruling pursuant to Rule 62.1.

CONCLUSION

The parties respectfully request that the Court grant their joint motion for an indicative ruling and enter the proposed Order indicating that it will, upon limited remand from the Sixth Circuit Court of Appeals:

(1) vacate the Memorandum and Orders from which the Defendants appealed (Doc. No. 37 entered on July 17, 2013, and Doc. Nos. 40 and 41 entered on August 15, 2013); and

(2) dismiss the Plaintiff's Complaint (Doc. No. 1) without prejudice.

Respectfully submitted,

ROBERT E. COOPER, JR.
Attorney General and Reporter

s/ Lee Ann Swarm
Lee Ann Swarm, TN BPR No. 013972
Legal Aid of East Tennessee
502 S. Gay Street, Suite 404
Knoxville, TN 37902
(865) 634-0484
lswarm@laet.org
Lenny L. Croce, TN BPR No. 006394
Legal Aid Society of Middle Tennessee
and the Cumberlands
P.O. Box 5209
Oak Ridge, TN 37831
(865) 483-8454
lcroce@las.org

COUNSEL FOR PLAINTIFF

s/Linda A. Ross
Linda A. Ross, TN BPR No. 004161
Deputy Attorney General
Linda.Ross@ag.tn.gov
Carolyn E. Reed, TN BPR No. 022248
Assistant Attorney General
Carolyn.Reed@ag.tn.gov
Office of the Attorney General
P.O. Box 20207
Nashville, TN 37202
(615) 741-1771

COUNSEL FOR DEFENDANTS

CERTIFICATE OF SERVICE

We hereby certify that a true and correct copy of the foregoing document has been served via the Court's electronic filing system on this 18th day of February, 2014.

s/Linda A. Ross

Exhibit 5. *Wilborn v. Martin*, Order dated February 18, 2014

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

JEREMY WILBORN, By Next Friend and Conservator, TARA WILBORN, Plaintiff, v. LARRY MARTIN, Commissioner, Tennessee Department of Finance and Administration; DARIN GORDON, Deputy Commissioner and Director, Bureau of TennCare; and PATTI KILLINGSWORTH, Assistant Commissioner, Chief of Long-Term Care, Bureau of TennCare, Defendants.	)	No. 3:13-cv-00574 Chief District Judge Haynes

~~[PROPOSED]~~ ORDER

This matter came before the Court upon the joint motion of the parties pursuant to Rule 62.1 of the Federal Rules of Civil Procedure asking this Court to indicate its willingness to accept the limited remand from the Court of Appeals and proceed to grant the parties' joint motion to vacate the Memorandum and Orders from which the Defendants appealed and to dismiss the Plaintiff's Complaint.

Having considered the parties' motion and the entire record, the Court is of the opinion, and so finds, that if the case is remanded to it by the Court of Appeals for the Sixth Circuit, it will grant the relief requested.

IT IS, THEREFORE, ORDERED BY THE COURT, that if the case is remanded to the District Court by the Court of Appeals, this Court will grant the parties' joint motion pursuant to Rule 62.1 of the Federal Rules of Civil Procedure and proceed to:

(1) vacate the Memorandum and Orders from which the Defendants appealed (Doc. No. 37 entered on July 17, 2013, and Doc. Nos. 40 and 41 entered on August 15, 2013); and

(2) dismiss the Plaintiff's Complaint (Doc. No. 1) without prejudice.

ENTERED this 19 day of February, 2014.

William J. Haynes, Jr.
Chief United States District Judge

STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Carolyn C. Matthews, Administrative Law Judge

Case No. 10-ALJ-08-0774-AP

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent

---

RESPONDENT'S RESPONSE TO THE AMICI CURIAE BRIEF OF PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.; SOUTH CAROLINA LEGAL SERVICES; THE SOUTH CAROLINA NATIONAL ASSOCIATION OF ELDER LAW ATTORNEYS; AND THE SOUTH CAROLINA APPLESEED LEGAL JUSTICE CENTER

Richard G. Hepfer
Deputy General Counsel
South Carolina Department of Health and Human Services
1801 Main Street
P.O. Box 8206
Columbia, South Carolina 29202-8206
Voice: (803) 898-2791
Fax: (803) 255-8210
Bar #3076
Attorney for the Respondent

RECEIVED
APR 11 2014
SC Court of Appeals

TABLE OF CONTENTS

Table of Authorities.....ii

Statement of Issues of Appeal.....1

Statement of the Case.....1

Arguments.....2

Background.....2

I. Whether the January 1, 2010, limitations on services provided in the ID/RD Waiver violate the ADA by placing the Appellant at sufficient risk of institutionalization 8

A. Is the risk speculative or serious?.....10

B. Fundamental Alteration or Reasonable Modificiation?.....14

II. The Petitioner asserts that the waiver limits are unenforceable because they were treated as a binding norm, and cites Hickey v. SCDHHS, Docket No. 10-ALJ-08-0656-AP in support.....16

Conclusion.....17

TABLE OF AUTHORITIES

CASES

Albert C. Meyers v. SCDHHS, 2012-ALJ-080173-AP.....7

Alexander v. Choate, 469 U.S. 287, 105 S. Ct. 712, 83 L.Ed.2d 661 (1985).....5, 18

Arc of Cal v. Douglas, 956 F. Supp. 2d 1113 (E.D. Cal. 2013).....14

Arc of Wash St. Inc. v. Braddock, 427 F.3d 615 (9th Cir. 2005).....12

Jane Doe v. South Carolina Dept. of Health and Human Services 398 S.C. 62, 727 S.E.2d 605, (S.C., 2011).....17

Fisher v. Oklahoma Health Care Authority, 335 F.3d 1175 (10th Cir.2003).....7, 13

Hampe v. Hamos, 917 F. Supp. 2d 805 (N.D. Ill.2013).....13

Hickey v. SCDHHS (10-ALJ-08-0656-AP).....16, 17

M.R. v. Dreyfus, 663 F.3d 1100 (9th Cir. 2011).....12

Olmstead v. L.C., 527 U.S. 581 (1999).....4, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18

Pashby v. Delia, 709 F.3d 307, at 325.....7, 11

Radaszewski v. Maram, 383 F.3d 599 (7th Cir. 2004).....12

[R. S.] v. SCDHHS, 09-MISC-042 (MR/RD).....2 & 7

Richard Stogsdill v. South Carolina Department of Health and Human Services, 10-ALJ-08-0774-AP.....2

Stogsdill v. Sebelius, 2013 WL 521483 (D.S.C., page 2, only the Westlaw cite is available at this time).....4

Wilborn v. Martin, ___ F. Supp. 2d ___, WL 4401856 (M.D. Tenn., Aug 15, 2013).....13

S. C.CONSTITUTION

S.C. Const. art. X, §7.....6

STATUTES

42 U.S.C. §1396 et seq.....17

42 U.S.C. §1396d(r) [also cited as §1905(r) of the Social Security Act].....7

Americans with Disabilities Act.....1, 8, 9, 10, 14

S.C. Code Ann. §11-9-20 6

S.C. Code Ann. §44-20-250 et seq.....16

S.C. Code Ann. §44-6-10 et. seq.....17

REGULATIONS

28 C.F.R. §35.130.....15

28 C.F.R. § 35.150(a)(3).....15

42 CFR §431.10.....17

42 CFR §440.230.....5

S.C. Code R. 126-300(D).....17

OTHER AUTHORITIES

Waiver Document(s),

http://www1.scdhhs.gov/openpublic/insideDHHS/Bureaus/BureauofLongTermCareServices/Mental%20RetardationRelated%20Disability%20Waiver.asp.....3

The DDSN's yearly Accountability Report, a public document,

http://ddsn.sc.gov/about/Documents/DDSN%20Acct%20Report%202013-Final.pdf.....4

Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* at *http://www.ada.gov/olmstead/olmstead_ta.htm*, ...10

RESPONDENT'S RESPONSE TO THE AMICI CURIAE BRIEF OF PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.; SOUTH CAROLINA LEGAL SERVICES; THE SOUTH CAROLINA NATIONAL ASSOCIATION OF ELDER LAW ATTORNEYS; AND THESOUTH CAROLINA APPLESEED LEGAL JUSTICE CENTER

STATEMENT OF THE ISSUES

I. Whether the January 1, 2010, limitations on services provided in the ID/RD Waiver violate the ADA by placing the Appellant at sufficient risk of institutionalization.

A. Is the risk speculative or serious?

B. Is accommodating the Appellant required by the ADA and *Olmstead*?

II. Whether the limits set in the January 1, 2010, Waiver renewal are unenforceable because they were not formally promulgated under the South Carolina Administrative Procedures Act (APA).

STATEMENT OF THE CASE

The Amici urge that the altered services provided to the Appellant under the 2010 Waiver renewal violate the integration mandate of the ADA as further defined in *Olmstead*, and as interpreted by the DOJ and several federal court preliminary injunctions. They further urge that, under State law, such program changes require promulgation through the SC Administrative Procedures Act.

Administration of this Waiver is the responsibility of the DHHS, but day-to-day management of the Waiver has been delegated to the DDSN. When a Medicaid applicant or recipient does not agree with a final determination of the DDSN, the managing agency, appeal may be made to the Appeals and Hearings Division of the DHHS and the DHHS is a Respondent.

The Appellant appealed the reduction in his services to the DHHS Division of Appeals and Hearings. On September 14, 2010, the DHHS Hearing Officer sustained the reductions. *R.S v. SCDHHS*, #10-MISC-042 (MR/RD). Appeal was taken to the Administrative Law Court, which affirmed in *Richard Stogsdill v. South Carolina Department of Health and Human Services*, 10-ALJ-08-0774-AP. Appeal was then taken to this court.

Essentially, on the first issue, the Amici argue that a fair number of injunctions issued by federal courts in the wake of the *Olmstead* decision have extended the meaning of *Olmstead* to some level of risk of institutionalization. On the second issue, the argument is that the Waiver changes affecting Appellant should have been promulgated through the Administrative Procedures Act.

ARGUMENTS

Background

The Appellant in this matter is a Medicaid-eligible individual, who has been receiving services under the South Carolina Intellectual Disabilities/Related Disabilities (ID/RD)

Waiver[1]. Under this Waiver, beneficiaries are provided a mix of services through the Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which, by having certain generic requirements of the Medicaid program "waived," 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 or community, in lieu of institutional services. On January 1, 2010, the five-year renewal of the ID/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 pertinent changes for this case are:

1) Personal Care (PC) Services were limited to twenty-eight (28) hours per week. Personal Care Aides (PCAs) assist Waiver participants with activities of daily living (bathing, dressing, feeding and toileting).;

2) Occupational, Speech and Physical Therapies were eliminated from the Waiver, but are available (if certain criteria are met) from the regular Medicaid Program.

3) The limits on Respite Services were set at sixty-eight (68) hours per month, but adjustable up to 240 hours per month according to the situation. Respite care services are similar to PCA services.

The current waiver documents including the Waiver and the approvals by the CMS are at http://www1.scdhhs.gov/openpublic/insideDHHS/Bureaus/BureauofLongTermCareServi

[1] Previous to the 2011 legislative year, this Waiver was called the Mental Retardation/Related Disabilities MR/RD Waiver.

ces/Mental%20RetardationRelated%20Disability%20Waiver.asp

The ID/RD Waiver has been in existence in South Carolina since the early 90's. See *Stogsdill v. Sebelius*, 2013 WL 521483 (D.S.C., page 2, only the Westlaw cite is available at this time)[2]. Obviously, the purpose of the Waiver was not originally to comply with the integration mandate of *Olmstead v. L.C.* 527 US 581 (1999). The purpose was just to encourage individuals to stay at home rather than go to an institution for care. Frankly, despite the opposite view (that a one-person institution is, due to inefficiencies of scale, the most expensive form of care), home care saves the State a great deal of money. The State would be much better off financially if all long term care could be provided at home. However, the State has inherited, so to speak, the fixed costs of an aging population of intellectually disabled individuals who for one reason or another want (or their families need them to) remain institutionalized. Often the reasons have to do with the amount of care needed and the capacity of the family. For the DDSN, Medicaid waivers are a very desirable method of providing care. Despite allegations to the contrary, neither Department has any interest in putting more individuals into institutions. The DDSN's yearly Accountability Report, a public document at: http://ddsn.sc.gov/about/Documents/DDSN%20Acct%20Report%202013-Final.pdf, page 31. shows how institutional care for this population has decreased and home and community based services have increased in the past ten (10) years. It is financially and therapeutically better to provide care in the home, in the Waiver.

[2] This Stogsdill case is the federal action that seeks the same relief as in this case. The citation is to a decision dismissing the federal Defendants.

The Amici have cited 42 CFR §440.230 as authority for the notion that the services provided to the Appellant are inadequate. We believe that the Amici have misunderstood the import of 42 CFR §440.230 as set forth in the Medicaid regulations. As explained in Respondent's Brief, the requirements in §440.230 do not apply to individual Plans of Care, but to the adequacy of the services to meet the general needs of the population served. The language of §440.230 does not require each individual's Plan of Care to be adequate. It does require the amount, duration, and scope of the services to be adequate to generally achieve the purposes of the service. Again, referring to the Supreme Court's earlier case of *Alexander v. Choate*, 469 U.S. 287, 105 S. Ct. 712, 83 L.Ed.2d 661 (1985), wherein the Court addressed this section of the regulations:

> [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."

With respect to individual needs, we agree with the Amici's statement that generally speaking an individual's activities of daily living can be objectively quantified. However, as we see the requirement, the State only needs to set up a program that meets the needs of the majority of the affected population. For example, PCA services are limited to twenty-eight (28) hours per week. In the usual case, it could be reasonable to figure two (2) hours each morning to prepare for the day and two (2) hours in the evening to prepare for bed, or twenty-eight (28) hours of personal care per week. All that is required, under §440.230, is that the level of service generally, not individually, meets the

needs of most of the cases.

If S.C. Const. art. X, §7 does not make it so for the State and General Assembly, then S.C. Code Ann. §11-9-20 at least makes it essential for state agencies to operate within their budgets. On January 1, 2010, in part to cope with budget cuts, the reconfiguration of the ID/RD waiver services went into effect. It takes a while, sometimes years, to plan, submit, and implement a waiver renewal. Some of the services, which, in the view of the agencies, had been overutilized, under informal limits, became subject to limits specified in the Waiver. Other, less expensive services were also more fully described in an effort to compensate for the loss of services. For example, Respite care (a service somewhat like the PCA service) can now be provided in increasing amounts to compensate for burdens on the primary caregivers.[3]

Thus, in accordance with the best practice, as they saw it, the DDSN and DHHS prepared the new Waiver for submission to The Centers for Medicare and Medicaid services (CMS). Public hearings were held throughout the State. CMS approved the Waiver in accordance with 42 CFR §441.300 et seq. All of the Medicaid application and approval requirements were met. Having done so, there was no doubt for the agencies that the implementation of the Waiver complied with the requirements of the federal agency that oversees the Medicaid Program. This was the "package" that the State could provide for adult ID/RD individuals.

[3] A basic requirement to participate in the Waivers is that there be informal supports such as family, so that the waiver services compliment the informal supports. See page 1 of the Waiver document.

Public notice of the changes was apparently sufficient so that the Appellant realized the potential impact on the amount of services he was to receive. On December 29, 2009, he appealed any reduction in his services. Although the original Hearing Officer acknowledged that the Appellant should have gotten a specific individualized Notice about any reduction, suspension, or termination of services, it is hard to see how the Appellant was prejudiced by the absence of such a Notice. He appealed before the effective date of implementation, he received an informal reconsideration by the Director of the DDSN (Record, p. 940), and he filed his own Brief (Record, p. 174) and received an agency Brief (Record, p. 151) before *the de novo* hearing. For several discussions about the lack of prejudicial effect of faulty notice, see the Hearing Officer's Decision in this case (*R.S. v. SCDHHS*, #10-MISC-042 (MR/RD), at page 8 of the Decision and page 16 of the Record), the similar Administrative Law Court case of *Albert C. Meyers* v. *SCDHHS*, 2012-ALJ-080173-AP (beginning at page 6 of that Order, which was supplemented by Respondent's letter to this court on March 10, 2014), and *Pashby v.Delia*, 709 F.3d 307, at 325.

The Amici argue that, in this case, the advice of the Appellant's attending physician was not given appropriate deference. EPSDT is the acronym for early and periodic screening, diagnosis and treatment, described at §1905(r) of the Social Security Act [42 U.S.C.§1396d(r)]. If the Appellant were a child, under the EPSDT provisions, and if the services he wanted were "medically necessary," they would have to be provided, if they were coverable under any Medicaid Program, even if the services were not covered under South Carolina's specific Medicaid program. EPSDT cases are about medical necessity.

This is not such a case.

This case, in which the Appellant is an adult, is about the "package" of services provided under the Waiver. In the *Olmstead* decision, Justices Breyer and Kennedy were concerned about discharging those in need of care into systems with too little supports. That type of "deference" discussed was the deference to the treating physicians' advice about discharge. The other type was deference to the "program funding decisions of the State policymakers." *Olmstead*, page 610. As far as we can see there is nothing in *Olmstead* about deferring to the treating physicians on what must be included in the "package" available to deinstitutionalized individuals. Nevertheless, well-reasoned, evidence-based recommendations of attending physicians should be given the utmost consideration, but it would be naïve of the State to allow such recommendations to be dispositive as to services. In this type of situation, we believe that physicians do not generally understand the scope of services available and often just agree with their patients that more is better.

South Carolina has chosen to provide a specific set of home and community based waiver services to intellectually disabled individuals or individuals with related disabilities through its Intellectual Disabilities and Related Disabilities (ID/RD) Waiver. Providing services in this way is optional for the State, and the State does not have to provide waiver services to take advantage of the other aspects of the regular Medicaid Program.

I. The Amici contend that the change in services, contained in the January 1, 2010, Waiver renewal violated the ADA as further explicated in the *Olmstead* decision by placing the Petitioner in serious risk of institutionalization.

Primarily, with respect to the institutionalization issue, the Department does not believe that the reconfiguration of services set forth in the Waiver would force individuals into institutions. That is speculative. At any rate, insufficient facts were alleged in the initial submissions of the Appellant to convince the Hearing Officer that the application of the Waiver provisions to the Appellant would have led to institutionalization.

The Hearing Officer and the Administrative Law Judge reviewed the arguments of the Parties, submitted in writing, and determined that the Waiver limitations were not in violation of *Olmstead*. It is true that numerous circuit courts throughout the country have issued preliminary injunctions against implementing waiver and other service reductions. Those courts have initially found that the reductions of services may be a violation of the ADA and *Olmstead* because they tend to put beneficiaries at risk of institutionalization. In issuing preliminary injunctions the courts have almost all preserved the *status quo* since the balance of hardship weighs against the beneficiaries. The Hearing Officer in this case declined to so hold and the Administrative Law Court agreed. Both decisions, we believe, relied substantially on the finding that instead of being a straightforward reduction in services, the South Carolina Waiver renewal was a reconfiguration of services. In this case, Respite Care, a similar service, was available to supplement the limitation in Personal Care Aide services (to 28 hours per week). At page 335 of the Record, it can be seen that by the time of the Hearing Officer's decision, the Appellant was authorized 104 hours monthly of Respite services. That translates into about twenty five (24) hours per week of a paid person to supervise and care for the Appellant, in lieu

of his regular caregiver. Altogether, with the 28 hours of PCA services, this equaled to over seven (7) hours per day of individual care hours. Plus the Waiver allows an adjustment up to 240 hours, or about fifty-six (56) weekly hours of Respite alone, not counting the twenty eight (28) hours of PCA services.

A. Is the risk speculative or serious?

The June 22, 2011, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* at *http://www.ada.gov/olmstead/olmstead_ta.htm*, asks and answers the question:

> **6. Do the ADA and *Olmstead* apply to persons at serious risk of institutionalization or segregation?**
> **A:** Yes, the ADA and the *Olmstead* decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings. Individuals need not wait until the harm of institutionalization or segregation occurs or is imminent. For example, a plaintiff could show sufficient risk of institutionalization to make out an *Olmstead* violation if a public entity's failure to provide community services or its cut to such services will likely cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution.

In the Statement's cover document the DOJ says that, "it reflects the views of the Department of Justice only."

One notes that the actual *Olmstead* decision is silent about any risk of institutionalization. That case dealt with individuals who were institutionalized and wanted to get out of the institution and resume community living. Even if the DOJ can find that the actual

Olmstead decision had directly spoken of the treat of institutionalization, the DOJ cannot bring itself to say that anything less than a serious risk of institutionalization violates the ADA.

The Amici correctly state on page 14 of their Brief that the *Olmstead* case dealt with individuals living in an institution. As also stated, much of the recent caselaw has extended the holding in *Olmstead* and held that a policy of the public entity may violate integration mandate even if it does not result in institutionalization, but only puts a participant in danger of institutionalization. However, the words of the DOJ are "serious risk." We would add that much of that caselaw consists of preliminary injunctions and settlement agreements, with very few of the cases going to final decision on the merits. The circuit court cases, for the most part, consist of remands and preliminary injunctions for which no final outcome is reported. It is certainly not difficult to understand why, in these cases, a circuit court judge would want to maintain the *status quo*. Finally, we note that the DOJ has persuasively intervened in many of these cases with its view of the impact and extension of *Olmstead*. Here are some examples:

In *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013), the district court's preliminary injunction was sustained by the circuit court. In a strong dissent, Judge Agee did not believe the injunction was warranted because 1) North Carolina could choose to completely eliminate the services in question; 2) the North Carolina constitution requires a balanced budget; 3) in *Olmstead*, at 603 the Supreme Court rejected the proposition that the ADA imposes a standard of care to individuals; 4) North Carolina , in structuring

services must take into account the needs of others with disabilities; 5) the risk of institutionalization was speculative; and *Olmstead*, at 607 allows consideration of budgetary constraints.

In *M.R. v. Dreyfus*, 663 F.3d 1100 (9th Cir. 2011), the circuit reversed a denial of injunctive relief by the district court. The injunction, put in place by the circuit court, remains the status of the case. The decision relied in part on the DOJ's filed Statement of Interest.

In *Arc of Wash St. Inc. v. Braddock*, 427 F.3d 615 (9th Cir. 2005), the Plaintiffs were excluded from the Waiver because there were insufficient slots to accommodate them, but the circuit court declined to require the state to increase the size of its Waiver Program, because, under *Olmstead* to do so would be a fundamental alteration of the program, and the State was making sufficient progress in deinstitutionalizing individuals.

In *Radaszewski v. Maram*, 383 F.3d 599 (7th Cir. 2004), the circuit court initially reversed and remanded the district court's decision to grant the State judgment on the pleadings against the Plaintiff who wanted full funding of at-home private duty nursing for her adult son. Upon remand the district court found that under *Olmstead*, the son should be provided sixteen (16) daily hours of skilled nursing care. 2008 WL 2097382 (N.D. Ill. Not reported in F. Supp. 2d). The circuit court holding was not a decision on the merits, but the district court found sufficient guidance in the circuit court's decision to

apply *Olmstead* as controlling. In this case, we do know the final outcome which was issued by the district court.

In *Fisher v. Oklahoma Health Care Auth.*, 335 F. 3d 1175 (10th Cir. 2003), the circuit court, finding that the Plaintiffs showed a high risk of institutionalization as a result of the State's policy which allowed for fewer drugs for community residents over residents of institutions, reversed the district court's summary judgment in favor of the State and remanded the case for further proceedings. No further proceedings are reported.

Even in some of the recent district court cases mentioned by the Amici, there is no further guidance than the maintenance of the *status quo*.

In *Wilborn v. Martin*, ___ F. Supp. 2d ___, WL 4401856 (M.D. Tenn., Aug 15, 2013), the district court found that Plaintiff was likely to succeed on his claim to have the State continue his home health benefits when he became an adult (turned 21) and maintained the *status quo* with a preliminary injunction.

In *Hampe v. Hamos*, 917 F. Supp. 2d 805 (N.D. Ill.2013), the district court denied cross motions for summary judgment, finding that there were still factual issues as to whether the Plaintiffs were qualified individuals and whether the accommodations requested were reasonable, but that the State could not rely on a fundamental alteration defense because it did not have a comprehensive working plan for community integration.

In *Arc of Cal v. Douglas*, 956 F. Supp. 2d 1113 (E.D. Cal. 2013), the district court denied the motion for a preliminary injunction by a provider of services to the developmentally disabled. The injunction sought to stop reimbursement reductions, but Plaintiffs were unable to show that were likely to prevail or suffer irreparable harm.

In sum, we do not know of a case in which a circuit court has made a final decision that a state has violated the Olmstead integration mandate by creating a serious risk of institutionalization. We believe that this is a construct of the DOJ that is an impermissible extrapolation of *Olmstead.*

B. Fundamental Alteration or Reasonable Modificiation

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 in the State 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 considered 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 essence, consideration must be given to the cost of the services, and the impact on the State's ability to continue to provide care for others in its charge. During the pendency of this case, the Departments have submitted a succession of Waiver amendments and renewals describing the types and limits of services available under this Waiver. Those amendments (including the limits) have been duly evaluated and approved by CMS. The DDSN has responsibility, under this Waiver and under State law, not only for providing services to the Appellant but to all of the other citizens in their system. See S.C. Code Ann. §44-20-250 et seq. In order to equitably apportion services, the Department must be allowed to reasonably limit otherwise "boundless" services. In short, if the Department spends too much on any one Participant, others in their system will suffer.

II. **The Petitioner asserts that the waiver limits are unenforceable because they were treated as a binding norm, and cites Hickey v. SCDHHS, Docket No. 10-ALJ-08-0656-AP in support.**

The Respondent relies on its position as set forth in its Final Brief, but just to recap:

Hickey was an administrative appeal that came up to the Administrative Law Court (ALC) from the Department's Division of Appeals and Hearings. The Department's Hearing Officer had dismissed the case without a hearing, finding that the Department's

policies were dispositive of the case. The ALC holding in *Hickey* was not that the Waiver limitations are unenforceable, but that they are not a binding norm and therefore may not be enforced without an opportunity for an evidentiary hearing.

The cases cited by the Amici about the characteristics of a policy as opposed to a regulation, show only that there is no clear rule in South Carolina. That may be fortunate. If State agencies had to promulgate every rate change and scope of service adjustment through the administrative process, the operation of state government would come to a standstill.

The Department is the duly designated single state agency for the administration of the Medicaid Program in South Carolina. 42 U.S.C. §1396 et. seq.; S.C. Code Ann. §44-6-10 et. seq.; and 42 CFR §431.10. The Department's regulations at S.C. Code R. 126-300(D) provide authority to make administrative changes in the Department's Programs. Furthermore, since the *Hickey* case, the South Carolina Supreme Court has specifically stated that the Department may establish enforceable criteria in the Waiver documents. *Jane Doe v. SCDHHS*, 398 S.C. 62, at 74.

CONCLUSION

In short, we believe that the DOJ's Statement and opinion letters submitted in cases has had the effect of impermissively extending violations of the "integration mandate" of *Olmstead*. At this point it seems that virtually any diminution or perceived insufficiency of home and community based services that creates the slightest risk of

institutionalization is seen by courts as a potential violation. On that basis quite a few courts in various circuits have chosen to maintain the *status quo* by issuing preliminary injunctions and denying summary judgments. This is much like an unfunded mandate in which the DOJ ratchets back the flexibility of the states and requires them to augment their original packages of home and community based services. The packages were put together by the states, considering their responsibilities to other disabled citizens, to do what they could to keep people in their homes and communities. No doubt when the straight-up decision on the merits is made, the federal circuit court will actually apply the more narrow holdings in *Alexander* and *Olmstead.* We urge you to do the same and affirm the Order of the Administrative Law Court.

Respectfully Submitted,

Richard G. Hepfer
Department of Health and
Humans Services
P. O. Box 8206
Columbia, SC 29202-8206
(803) 898-2791
Attorney for the Respondent

Columbia, SC
April 11, 2012

STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED
APR 11 2014
SC Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Carolyn C. Matthews, Administrative Law Judge

Case No. 10-ALJ-08-0774-AP

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent

CERTIFICATE OF SERVICE

I hereby certify that I am a Paralegal for the Respondent in the above-captioned matter and that on this 11th day of April, 2014, in Columbia, South Carolina, I served a copy of the forgoing Respondent's Response to the Amici Curiae Brief of Protection and Advocacy for People with Disabilities, Inc.; South Carolina Legal Services; the South Carolina National Association of Elder Law Attorneys; and the South Carolina Appleseed Legal Justice Center on the following persons by depositing the same in the United States Mail, postage paid, and addressed as follows:

Patricia L. Harrison
611 Holly Street
Columbia, SC 29205

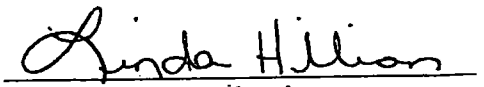
Anna Maria Darwin
Protection and Advocacy for
People with Disabilities
545 N. Pleasantburg Drive, Suite 106
Greenville, SC 29607

Sarah Garland St. Onge
Protection and Advocacy for
People with Disabilities
3710 Lnadmark Drive, Suite 208
Columbia, SC 29204

Amy Landers May
South Carolina Chapter of the National
Academy of Elder Law Attorneys
c/o the Landers May Firm
601 Devine Street
Columbia, SC 29201

Kirby Mitchell
South Carolina Legal Services
701 South Main Street
Greenville, SC 29601

Stephen Suggs
South Carolina Appleseed Legal
Justice Center
PO Box 7187
Columbia, SC 29202



Linda Hillian, Paralegal
Office of General Counsel
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Voice: (803) 898-2794
Fax (803) 255-8210

SOUTH CAROLINA
Healthy Connections
MEDICAID

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

March 10, 2014

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

Re: Richard Stogsdill v. SCDHHS, Case Tracking # 2013-000762
Trial Court Case No. 2010ALJ080774AP

Dear Ms. Kitchings:

Pursuant to 208(b)(7), we are enclosing a copy of Case #12-ALJ-08-0173-AP (A.C.M. v. SCDHHS) issued by the Administrative Law Court. We believe that this case is instructive on the issue of adequate notice, the promulgation issue and issue of deference to the treating physician. Copies have been sent to all other counsel.

If there are questions or anything else is required, my direct is (803).898-2791.

Sincerely,

Richard G. Hepfer
Deputy General Counsel

cc: Patricia L. Harrison
Anna Maria Darwin
Sarah Garland St. Onge
Amy Landers May
Kirby Mitchell
Stephen Suggs

RECEIVED
MAR 11 2014
SC Court of Appeals

FILED
FEB 03 2014
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

RECEIVED
MAR 11 2014
SC Court of Appeals

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

RECEIVED
FEB 04 2014
SCDHHS
Office of General Counsel

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

IN STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

Case # 10-ALJ-08-0774-AP

Stogstill, Richard — Appellant

v.

South Carolina Department of Health and Human Services, — Respondent

---

REPLY OF AMICI PETITIONERS TO RESPONDENT'S RETURN TO PETITIONERS' MOTION FOR LEAVE TO FILE AN AMICI BRIEF IN SUPPORT OF APPELLANT

Pursuant to Rule 213, SCACR, the four (4) Amici Petitioners – Protection and Advocacy for People with Disabilities, Inc., the South Carolina Chapter of the National Academy of Elder Law Attorneys, South Carolina Legal Services, and South Carolina Appleseed Legal Justice Center – hereby reply to the Respondent's Return to Petitioner's Motion for Leave to File an Amici Brief as follows:

RECEIVED
MAR 07 2014
SC Court of Appeals

(1) Petitioners' Motion Should be Granted Because Petitioners' Amici Brief is Desirable in this Case

Petitioners' Amici Brief directly addresses both the complex relevant legal issues and case law – the Americans With Disabilities Act (ADA), the Administrative Procedures Act (APA), *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999) – as well as the practical consequences for many low-income and disabled South Carolinians on the legal issues squarely before the Court in this case. This Court's decision in this case will have broad legal and practical effects beyond those contemplated by the named parties directly involved in this case, and thus, the filing of this Petitioners' Amici Brief both assists this Court with a matter of urgent public concern and demonstrates an efficient use of these non-profit organizations' limited resources.

(2) Oral Argument Should Not be Delayed Based on the Circumstances Present in this Case

Considering all the circumstances, Petitioners see no reason the oral argument scheduled for March 12, 2014 before this Court should be delayed, and Petitioners fully support Respondent's request to be granted ample time after oral argument to submit a written response to Petitioners' Amici Brief.

THEREFORE, amici request that the Court grant it leave to file an Amici Curiae brief in support of the Appellant in the matter of Stogstill v. South Carolina Department of Health and Human Services.

This the 7th day of March, 2014

Respectfully submitted,

PROTECTION AND ADVOCACY FOR
PEOPLE WITH DISABILITIES, INC.

BY: _____
ANNA MARIA DARWIN
S.C. Bar #: 15252
545 N. Pleasantburg Drive, Suite 106
Greenville, SC 29607
(864) 235-0273
darwin@pandasc.org

SARAH GARLAND ST. ONGE
S.C. Bar #: 4112
3710 Landmark Drive, Suite 208
Columbia, SC 29204
(803) 782-0639
stonge@pandsc.org

SOUTH CAROLINA CHAPTER OF
THE NATIONAL ACADEMY OF
ELDER LAW ATTORNEYS

BY: _____
AMY LANDERS MAY
S.C. Bar # 69551
The Landers May Firm
601 Devine Street
Columbia, SC 29201
(803) 799-0094
amy@landersmayfirm.com

SOUTH CAROLINA LEGAL SERVICES

BY: _____
KIRBY MITCHELL
S.C. Bar #: 11640
South Carolina Legal Services
701 South Main Street
Greenville, SC 29601
(864) 679-3247
kirbymitchell@sclegal.org

SOUTH CAROLINA APPLESEED
LEGAL JUSTICE CENTER

BY: _____
STEPHEN SUGGS
S.C. Bar #: 16970
PO Box 7187
Columbia, SC 29202
(803) 779-1113
SSuggs@scjustice.org

Attorneys for Amici Curiae

Columbia, South Carolina
March 7, 2014

SOUTH CAROLINA CHAPTER OF
THE NATIONAL ACADEMY OF
ELDER LAW ATTORNEYS

BY:_____
AMY LANDERS MAY
S.C. Bar # 69551
The Landers May Firm
601 Devine Street
Columbia, SC 29201
(803) 799-0094
amy@landersmayfirm.com

SOUTH CAROLINA LEGAL SERVICES

BY:_____
KIRBY MITCHELL
S.C. Bar #: 11640
South Carolina Legal Services
701 South Main Street
Greenville, SC 29601
(864) 679-3247
kirbymitchell@sclegal.org

SOUTH CAROLINA APPLESEED
LEGAL JUSTICE CENTER

BY:_____
STEPHEN SUGGS
S.C. Bar #: 16970
PO Box 7187
Columbia, SC 29202
(803) 779-1113
SSuggs@scjustice.org

Attorneys for Amici Curiae

_____, South Carolina
March 7, 2014

SOUTH CAROLINA CHAPTER OF
THE NATIONAL ACADEMY OF
ELDER LAW ATTORNEYS

BY:_____
AMY LANDERS MAY
S.C. Bar # 69551
The Landers May Firm
601 Devine Street
Columbia, SC 29201
(803) 799-0094
amy@landersmayfirm.com

SOUTH CAROLINA LEGAL SERVICES

BY:_____
KIRBY MITCHELL
S.C. Bar #: 11640
South Carolina Legal Services
701 South Main Street
Greenville, SC 29601
(864) 679-3247
kirbymitchell@sclegal.org

SOUTH CAROLINA APPLESEED
LEGAL JUSTICE CENTER

BY:_____
STEPHEN SUGGS
S.C. Bar #: 16970
PO Box 7187
Columbia, SC 29202
(803) 779-1113
SSuggs@scjustice.org

Attorneys for Amici Curiae

March 7, 2014, South Carolina
March 7, 2014

STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Carolyn C. Matthews, Administrative Law Judge

Case No. 10-ALJ-08-0774-AP

RECEIVED
FEB 27 2014
Court of Appeals

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent

---

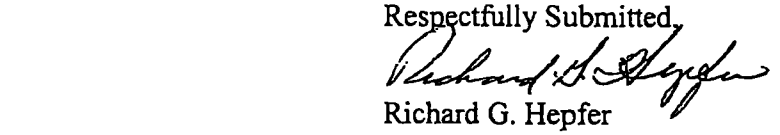
RETURN TO THE MOTION OF PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC., SOUTH CAROLINA CHAPTER OF THE NATIONAL ACADEMY OF ELDER LAW ATTORNEYS, SOUTH CAROLIN LEGAL SERVICES, AND APPLESEED LEGAL JUSTICE CENTER FOR LEAVE TO FILE AMICI BRIEF IN SUPPORT OF APPELLANT

In accordance with Rule 240(e) SCACR, the Respondent in this matter hereby returns to the above referenced Motion:

1) The Motion should be denied because it does not fully comply with Rule 213 SCACR in that, although it specifies the interests of the applicants, it only implies and does not state the reasons why the Amici Brief is desirable.
2) Oral arguments in this matter have been set for March 12, 2014. If the court determines that the Amici Brief is necessary for the full explication of the issues, the Respondent respectfully requests that, under Rule 213 SCACR, ample time be

provided for the Respondent to prepare a considered Response to the points raised by the Amici Brief.

Respectfully Submitted,



Richard G. Hepfer
Department of Health and
Humans Services
P. O. Box 8206
Columbia, SC 29202-8206
(803) 898-2791
Attorney for the Respondent
Bar # 3076

Columbia, SC
February 27, 2014

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

TELEPHONE (803) 256-2017 FAX (803) 256-2213

February 26, 2014

Jenny Abbott Kitchings, Clerk of Court
The South Carolina Court of Appeals
1015 Sumter Street
Columbia, SC 29201

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

Dear Ms. Kitchings:

We are enclosing two orders issued by the SCDHHS Program Director, Division of Appeals and Hearings, in *Brook Waddle v. SCDHHS*. These orders refer to Issues 5 (due process) and 6 (reasonable promptness). I have discussed our intention to submit this case pursuant to Rule 208(b)(7) with Mr. Hepfer. The reason for supplemental cites is that *Brook Waddle v. SCDHHS* addresses violation of the notice requirements of the Medicaid Act, due process, and the agency's position on whether the SCDHHS Office of Appeals and Hearings has jurisdiction to exceed the waiver caps. This case is on appeal to the South Carolina Administrative Law Court.

Thank you for your assistance and please let me know if there is anything else we need to provide the Court before oral arguments that are scheduled for March 12.

Cordially,

Patricia L. Harrison

Enclosures

c: Richard Hepfer, Esq.
Anna Maria Darwin, Esq.
Sarah St. Onge, Esq.
Amy May, Esq.
Kirby Mitchell, Esq.
Stephen Suggs, Esq.

RECEIVED
FEB 26 2014
SC Court of Appeals

Rec'd Nov 20, 2013
RH

SOUTH CAROLINA
Healthy Connections
MEDICAID

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

November 19, 2013

CERTIFIED MAIL

Patricia Harrison, Esquire
611 Holly Street
Columbia SC 29205

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

Dear Ms. Harrison:

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

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

Sincerely,

Elizabeth B. Hutto

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

EBH/ss
Enclosures (2)

RECEIVED
FEB 26 2014
SC Court of Appeals

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 administrative 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 Court:

(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 motion. 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.

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

RECEIVED
FEB 26 2014
SC Court of Appeals

JURISDICTION

Procedure in this case is governed by the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services to administer various programs and grants (See e.g., S.C. Code Ann. § 44-6-10, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (27 S.C. Code Regs. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. § 1-23-310, et seq.).

BACKGROUND

The Petitioner in this matter was injured in an automobile accident in 2005, which rendered her quadriplegic. At the time of the accident, the Petitioner was 17 years old. She has difficulty speaking due to subsequent injuries to her larynx sustained during her initial hospitalization. She breathes through a tracheostomy. The Petitioner became eligible for Medicaid-covered services shortly after the accident. Since her May, 2007 return home, she has been receiving services under the South Carolina Head and Spinal Cord Injury (HASCI) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through the South Carolina

Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which, by getting the federal agency to "waive" certain generic requirements of the Medicaid program, States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. This and other Waivers operated by SCDDSN are for home and community based services under Section 1915(c) of the Social Security Act [42 USC §1396n(c)]. These types of Waivers allow services to be provided in the home or community, in lieu of institutional services. The South Carolina Department of Health and Human Services (SCDHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and is responsible for the overall administration of the Waiver.

In February 2007, in anticipation of the Petitioner's discharge home from her initial hospital stay, the Petitioner's Service Coordinator (Ms. Gosnell, at that time) completed her Service Plan. The parties disputed several aspects of that plan including the nursing and service hours to be provided to Petitioner upon her discharge home. That dispute forms the basis of the present appeal. There are three types of services at issue in this case:

1. RN services, where a registered nurse can provide nursing care, complete certain medical tasks, and assess the Waiver Participant;
2. LPN services, where a licensed practical nurse can provide nursing care and complete certain medical tasks;
3. Attendant care services, where a qualified provider can help with activities of daily living such as light housekeeping, feeding, clothing, or bathing. Only an RN, LPN, or trained family member can provide skilled care.

In 2007, this matter was originally before the Appeals Division of the SCDHHS, but was dismissed, essentially for confusion about joinder of the issues. Thereupon, the matter was

appealed to the Administrative Law Court (ALC) which remanded the matter for an evidentiary hearing at SCDHHS. After the hearing (April 14, 2009), the SCDHHS Hearing Officer's Decision, issued on July 9, 2009, was appealed and, on July 30, 2012, the ALC once again remanded the case to the SCDHHS Appeals Division for a determination of the five issues listed below.

A hearing was held over two days: October 25, 2012 and October 31, 2012 at the SCDHHS Offices. Richard Hepfer, Esquire, represented Respondent and called as witnesses: Dr. Linda Veldheer, SCDDSN, Director, HASCI Division; Anita Atwood, SCDHHS, HASCI Waiver Administrator; Zanipha Mohammed, SCDHHS, Durable Medical Equipment; and Ashley Wingo, the Petitioner's current Service Coordinator. Patricia Harrison, Esquire, represented the Petitioner and called as witnesses: Sandra Ray, Speech Pathologist and Rhonda Galus, the Petitioner's LPN. In addition to the testimony of the witnesses, I have Declaration Statements from the Petitioner, her mother, S.W., her father, J.W., and Kathy Hoover, RN. Additionally, I have affidavits of Don Kovach of Dynavox Mayer-Johnson and Lennie Mullis.

The following documents were admitted as exhibits for the Petitioner:

1. A 9/24/2012 letter from Linda Veldheer to Petitioner indicating that, if the Petitioner approved, her services would be restored to the May 2007 levels;
2. Charles Lea Center's Estimated Annual cost of services for Petitioner for 2010, 2011, and 2012;
3. A 3/14/2007 Notice of Denial of an apparent request for additional nursing services;
4. A 3/30/2007 Notice of Denial of an apparent request for additional nursing services;
5. A 3/29/2007 Physician's Order for Petitioner for 28 hours per week of RN and 84 hours per week of LPN services, and a companion letter from Dr. Silvestri;

6. Various DDSN Manual provisions;

7. A March 18, 2010, Discharge Summary from Greenville Hospital System;

8. The Service Coordinators' Record of Contact for the Petitioner dated for various times between 12/1/09 – 09/27/12;

9. DDSN HASCI Form 15 (9-10) dated 2/22/12 by Dr. Katherine Lumpkin;

10. ICD-9 Description of the E2510 Speech Generating Device;

11. Telephone Declaration of J. W. taken by Petitioner's attorney;

12. Telephone Declaration of B. W. taken by Petitioner's attorney;

13. Telephone Declaration of S. W. taken by Petitioner's attorney;

14. Affidavit of Don Kovach;

15. Declaration of Kathy Hoover, RN;

16. Attachments to Declaration of Kathy Hoover, RN;

17. Section 2 of the Home Health Services Manual, updated 10/01/12;

18. Section 2 of the Private Rehabilitation Therapy and Audiology Services Manual, update 10/01/12;

19. An August 20, 2010, News Release from the Comptroller General's Office about the budget challenges of FY 2010;

20. A May 8, 2009, cover letter enclosing documentation about the request for the speech generating device;

21. Affidavit of Lennie Mullis;

22. Packet of documents regarding the requested speech generating device;

23. Detailed Claims Report of Petitioner dated 10/16/2012;

24. Personal Care Needs Form, no date, for B.W.;

25. DDSN Annual Accountability Report, FY 2011-2012;

26. Document entitled Head and Spinal Cord Injury (HASCI) Waiver Recommendations for Revised Service Limits, Attachment D;

27. DDSN Service Coordination Manual, Revised July 1, 2011;

28. Documents from a Nursing Services Review of Petitioner by Vivian Koon; and

29. Photographs of Petitioner.

The following documents were admitted as exhibits for the Respondent:

1. Documents related to the original request for a speech generating device; and

2. The Current HASCI Waiver document.

In addition to the exhibits listed above, the 120 page record of the 2007 attempted appeal along with the 1,582 page record of the 2009 fair hearing were also a part of the record in the current matter. Note that the undersigned Hearing Officer was new to this case in 2012 as the Hearing Officer who presided over the 2007 and 2009 matters is deceased.

ISSUES

The Administrative Law Court has remanded this appeal to determine the following issues:

1. The weekly hours of registered nursing that are needed by the Petitioner, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.

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

3. The number of hours of the authorized care described in #2, above, that has been provided by the mother (according to her qualifications), and the cost of that care, which amount shall be paid to the mother.

4. In the future, the mother should be allowed to provide whatever care she is qualified to provide within the authorized hours of service set as described in #2, above, and shall be paid for such services at a rate to be determined upon remand.

5. The cost of an average digital speech device of the type described by Dr. Burton shall be determined and paid to the Petitioner to defray the cost of the more expensive device she purchased.

HISTORY OF SERVICE HOURS DISPUTE

The Service Plan drafted by the Petitioner's Service Coordinator in February 2007 required 28 hours per week of Personal Care Aide (PCA) services; 56 hours per week of nursing care provided by a Licensed Practical Nurse (LPN); 14 hours per week of nursing care provided by a Registered Nurse (RN). The RN services were to be evaluated after 30 days but continue in some amount per week. The care to be provided under this Service Plan totaled 98 hours per week. However, the Petitioner's treating physicians ordered 28 hours per week of RN services; 84 hours per week of LPN services for a total of 112 hours of skilled care per week. The treating physician also ordered attendant care whenever a nurse was not present. Presumably the attendant hours would be covered by the Petitioner's parents as the Petitioner's mother was the only attendant available that could provide skilled care. The Petitioner remained hospitalized as the parties continued to negotiate the Petitioner's care upon discharge. B.W. v. SCDHHS, Docket No. 09-ALJ-08-03440AP (S.C.A.L.C. July 30, 2012).

On March 14, 2007, DDSN issued a HASCI Notice of Denial form notifying the Petitioner that Medicaid Waiver Nursing Services were denied for exceeding service limits. "B___ will already be receiving the maximum number of RN hours per week (44) and can not receive additional hours of LPN services according to the HASCI waiver guidelines. The HASCI waiver manual specifically states: The maximum number of nursing services/units that can be funded by the HASCI waiver is 60 hours per week provided by an LPN-OR-44 hours per week provided by an RN." Petitioner's Exhibit 3. This notice did not include any reference to a supporting statute or regulation as a basis for this decision nor did the notice provide any information regarding the continuation of benefits pending an appeal. The Petitioner was under 21 at the time this notice was issued. This notice was sent to the Petitioner's home even though she was hospitalized at this time. Although the notice cites a maximum number of nursing hours, according to the Director of the HASCI Waiver, Dr. Linda Veldheer, there were no limits under the Waiver at this time. Instead, this notice was following "HASCI Waiver procedures." T. at 60. At this time HASCI did not have caps that were part of the Waiver document but SCDDSN was following "limits we were applying at the direction of HHS." Id.

On March 29, 2007, the Petitioner's treating physician, Dr. Silvestri, ordered 84 hours per week of LPN care; 24 hours per week of RN care and attendant care at all times when the nurse was not present. On March 30, 2007, DDSN sent a denial notice stating that due to the Medicaid Waiver, the ordered Nursing Services exceeds service limits: "HASCI Waiver services (home and community based services) can not be offered when it can reasonably be expected that the cost of services to B___ would exceed the cost of a nursing facility level of care." Petitioner's Exhibit 4. Again, no statute or regulations were cited on this notice nor was there any justification or analysis regarding whether the cost for this care would be greater than the cost of

a nursing home. Ms. Atwood testified that the Waiver limits looked at the aggregate cost of institutional vs. non-institutional care and that there were no caps applied to individuals. T. at 10-14. Dr. Veldheer testified that it would be improper for a denial to be based on the individual's service costing more than nursing home care since there are no individual limits. T. at 57. The Petitioner was under 21 at this time. This notice made no mention of continued benefits pending appeal. Like the previous notice, this notice was also sent to the Petitioner's home although she was still hospitalized at MUSC.

The notices sent to B.W. refer to limits within the HASCI Waiver. However, the Respondent presented conflicting testimony regarding whether there was in fact a limit within the HASCI Waiver at this time. According to Ms. Atwood, the HASCI Waiver Administrator for SCDHHS, there were no limits on nursing and attendant care services within the HASCI Waiver prior to July 2008. T. at 6. Dr. Veldheer asserted that SCDDSN applied limits to HASCI Waiver participants in 2007. T. at 61. Dr. Veldheer explained that, although there were no limits in the Waiver document at this time, "we were applying those kinds of limits informally." T. at 42. Dr. Veldheer claimed that in spite of the language contained in the March 30, 2007 notice, SCDDSN was not applying an individual limit. She seemed to indicate the notice is a local issue: "The service coordinator wrote this comment. I don't agree with this comment but this is what a service coordinator at the local level wrote." T. at 61. In rebuttal testimony, Dr. Veldheer contradicted her earlier statement and testified that the HASCI Waiver did not have an individual limit at the time the 2007 notices were issued. T. at 243.

On April 28, 2007, while still hospitalized, the Petitioner requested the present appeal due to the denial of the nursing and attendant care services ordered by her treating physicians. The

Petitioner was discharged on May 8, 2007, and was to receive the services that had been included in the service plan created by the Service Coordinator in February 2007.

On May 9, 2007, the day following the Petitioner's discharge from the hospital, she sent a letter to SCDDSN and SCDHHS stating she "...reserves all rights. Her acceptance of services in order to secure her release from her current, considerably more expensive institutional placement cannot be construed as a waiver, consent, limitation, estoppel, or other indication of agreement with the restrictions imposed by SCDDSN and SCDHHS." Record of 2007 Matter at 58.

In July 2008, while this appeal was pending, the Respondent reduced the Petitioner's service hours to 32 hours per week of LPN and 48 hours per week of attendant care plus seven hours per month of respite care. T. at 44. There is no notice in the record regarding this service reduction. This reduction occurred while the current appeal was pending and while the Petitioner was under 21. Dr. Veldheer testified that in July 2008, services were limited to 60 hours of LPN per week or 45 hours of RN per week or a combination not to exceed $1,425 based on an LPN rate of $23.75 per hour; RN rate of $31.35 per hour. T. at 43. However, when asked about this weekly limit on cross examination, Dr. Veldheer asserts, "I never said that...We've never had weekly limits." T. at 66. According to Ms. Atwood, there were no limits on nursing services or attendant care prior to July 2008. T. at 6. The Petitioner was still not receiving RN services due to the Service Coordinator's inability to locate an RN and the mistaken idea that the RN could only provide 2 hours of care per day.

In July 2009, while this appeal was pending, the Petitioner's nursing hours were again reduced. Her LPN hours were brought down to 22 hours per week while the attendant care was increased to 48 hours per week along with 12 hours per week of respite care. T. at 45. There is

no notice in the record regarding this reduction. As with the 2008 service reductions, the 2009 reductions occurred while the current appeal was pending.

In 2010, the HASCI Waiver was renewed and an across the board cut was instituted. There was no individual assessment to determine whether the cuts were appropriate, no cost analysis to determine if less expensive services could be used, nor any medical review of the consequences of the cuts. T. at 20-21and 25. At this time, Petitioner's services remained the same (22 hours per week LPN and 48 hours per week attendant) as the 2009 reduction had already put her services within the across the board cuts. T. at 45. According to the Respondent, since 2010, the combination of nursing and attendant care cannot exceed 70 hours per week (10 hours per day). Prior to 2010, there was a 12 hour per day limit (total limit of 84 hours per week).

In 2011, Petitioner's services went to 34 hours per week of LPN, 36 hours per week of attendant care, and 12 hours per week of respite care. This is the Petitioner's current authorization and is the Waiver limit for the combination of attendant care and nursing, according to Dr. Veldheer. T. at 45.

Prior to the hearing, the Respondent sent the Petitioner a letter offering to restore her HASCI Waiver services to the levels of May 2007 which the letter characterized as: 2-3 hours per week of RN services, 8 hours per day of LPN services, 4 hours per day of attendant care, physical therapy (P.T.), occupational therapy (O.T.), speech therapy (S.T.), and Psychological services. Petitioner's Exhibit 1. This offer totaled 83-84 hours per week of skilled and attendant care which exceeds the current waiver limits. The timing of the letter indicates that it was sent in an attempt to settle this dispute.

At some point while this appeal was pending, the Petitioner's parents divorced and the Petitioner's mother, S.W., became the Petitioner's sole caregiver.

Issues 1 and 2 will be considered together as the facts and law are inter-related.

Issue 1 - The weekly hours of registered nursing that are needed by the Petitioner, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.

Issue 2 – How many weekly hours of each type of care and services have been needed by Appellant during the course of her treatment since her discharge from the hospital in May 2007 consistent with the Medicaid Program, and the principal that the mother is not legally responsible for caring for the Appellant.

DISCUSSION

At the time of the Petitioner's return home in 2007, her Service Plan called for two hours per day, seven days per week of RN care; however, the Service Coordinator was unable to find an RN in the area willing to work a two hour shift and those care hours went unfilled. As the limited daily hours appeared to be a roadblock to getting the Petitioner the RN services to which she was entitled, the Petitioner's parents asked the Service Coordinator whether they could combine the 14 hours per week so that an RN could provide services for longer periods of time over fewer days. The Service Coordinator informed the family that it was not possible to combine these nursing hours under the Waiver and that they must use two hours per day. Petitioner's Exhibit 13, Declaration of S.W. at 6. However, two witnesses for the Respondent, Ms. Atwood and Dr. Veldheer, acknowledged that Waiver participants can combine nursing hours. T. at 20 and 82. Both parties agreed that it is not possible to find an RN who would work a two hour shift. T. 199-200 and 221. Dr. Veldheer testified that because it is difficult to get an

with nursing needs will receive. T. at 226-227. The centralized nurse can determine whether a service is medically necessary. T. at 22.

Dr. Veldheer stated that if a treating physician ordered nursing hours that exceeded waiver limits, the SCDDSN centralized nurse would not give any deference to that medical order. Dr. Veldheer explained that the form used by SCDDSN does not allow the doctor to designate a recommended number of nursing hours. The doctor identifies the condition and the specific skilled nursing care they require. If the doctor ordered hours that exceeded limits, the centralized nurse would "not consider it." T. at 232.

The Respondent has not presented any medical witnesses with direct knowledge of the Petitioner's condition at either of the two hearings in this matter. The Respondent's Medical Director, Dr. Marion Burton, testified during the 2009 hearing. Dr. Burton had not met the Petitioner prior to the 2009 hearing. He was "somewhat familiar" with the case. Record of 2009 Matter at 47-48. Although Dr. Burton could not recall the specific details of the care the Petitioner was to receive upon discharge from the hospital, he believed she was to receive about 50 hours of skilled care per week and that, along with the supporting care of the parents and attendant care, was adequate to maintain the Petitioner at home. *Id.* He has no training in the treatment of head or spinal cord injuries and admitted that he was only vaguely familiar with the HASCI Waiver program. Record of 2009 Matter at 92-93. Dr. Burton admitted that he did not have the expertise to override the orders of a treating physician. His decision to deny services was based upon Department guidance and the SCDHHS provider manual policy. Record of 2009 Matter at 97, 109-111.

Tracheostomy in place – tracheoesophageal fistula

Dysphagia – GERD

Hypothyroidism

Staph coag negative bacteremia – treated with Rocephin"

Petitioner's Exhibit 28 at 2.

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

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

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

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

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

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

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

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

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

I therefore find:

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

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

3. The Petitioner's Service Plan also authorized 56 hours per week of LPN care and 28 hours of Attendant care.

4. The denial notices that were issued to the Petitioner prior to her initial discharge from the hospital were improper as they did not contain the statutes or regulations the actions were based upon nor did they provide instruction on how to appeal the negative action. The denial notices were sent to the Petitioner's home, although she was hospitalized at the time. Additionally, the reasons for the denials given in these notices were erroneous according to the testimony of the Respondent. The Petitioner was under 21 at the time that the denial notices were issued. The Petitioner turned 21 on January 14, 2009.

5. While pending the resolution of this appeal, the Petitioner's services were improperly reduced several times. The reductions occurred without notice and the opportunity to appeal. The reduction in 2008 occurred before the Petitioner turned 21.

6. In July 2008, the Petitioner's hours were reduced to 32 hours of LPN and 48 hours of attendant care (total of 80 hours per week). There was no notice provided to the Petitioner for this reduction.

7. In 2009, the Respondent again improperly reduced the Petitioner's service hours to 70 hours per week of combined LPN and Attendant Care. This reduction occurred during the pendency of this appeal. The Respondent again failed to provide proper notice.

8. At some point after the Petitioner was discharged from MUSC in 2007, her father moved out of the home and the Petitioner's mother became the sole family member providing

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

9. Upon discharge on May 9, 2007, the Petitioner was unable to find a provider of RN services willing to work the authorized hours per week and thus was unable to fill the position. The inability to locate a suitable RN was due to the Service Coordinator's erroneous assertion that the Petitioner could only receive RN hours in daily two hour increments. The Petitioner and her family relied upon this erroneous assertion. The Petitioner still has not received RN hours in her home since her initial discharge from the hospital in 2007.

10. During the pendency of this appeal, the Petitioner's mother has provided all of the care that the Respondent failed to provide due to both miscommunication and service reductions.

11. Witnesses for both parties concur that it is not possible to locate an RN who would be willing to travel to work for such a short period each day. The Petitioner and RN provider should have had the opportunity to schedule the RN hours so that the schedule best met their mutual needs.

12. The Petitioner was not re-evaluated 30 days after her initial discharge from the hospital to determine whether the 14 hours per week of RN should continue.

13. Under the current nursing hours review process, the Respondent does not seek the recommendation of the treating doctor regarding nursing hours needed by HASCI Waiver participants. The current authorization process for nursing hours requires a centralized SCDDSN nurse to perform a record review.

14. The Respondent has not provided any records which indicate that a physician for the Respondent has ever reviewed the Petitioner's medical needs.

15. The medical records review conducted by the Respondent and the testimony of witnesses for both parties indicate that the Petitioner is a quadriplegic, who relies upon a tracheostomy to breathe, and suffers from several complicated medical conditions including recurrent pneumonia, seizures, and skin break down. Due to her condition, she is at continued risk for infection. She requires constant care and cannot be left alone. Based on the testimony of witnesses for both parties, an RN should have been involved in the Petitioner's care on at least a weekly basis due to the complexity of the Petitioner's medical needs.

16. The Respondent relied upon the evaluation of a nurse to determine the hours of skilled care needed by HASCI Waiver participants.

17. An RN can assess the Petitioner's lung functioning, skin condition, and infection risks. According to the testimony of both parties, the Petitioner would benefit from a weekly assessment conducted by an RN.

18. Due to the Petitioner's complicated medical conditions and her dependence upon a single caregiver, she should receive the maximum services available under the HASCI Waiver. For this Petitioner, a four hour block of RN services is the minimum necessary per week. However, under the current rules, the Petitioner may adjust the nursing hours between RN and LPN services. The Petitioner may therefore receive up to a maximum of 45 hours per week of RN care should she so choose, bearing in mind that limit works in tandem with the limits for LPN services and an increase in RN hours may result in a

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

19. The Petitioner would have benefitted from 14 hours of RN care per week through June 30, 2007, and at least four 4 hours of RN services with increased RN, if the Petitioner had desired, up to the waiver limit. The Petitioner should have received RN services weekly through the present time. The Petitioner has been maintained at home with fewer services than those to which she was entitled due to the extraordinary efforts and dedication of her mother.

20. The Petitioner's benefits should have continued at the levels ordered by her treating physician during the pendency of this appeal.

21. There are RNs available in the Petitioner's service area who will cover four hours or more of care per week.

LEGAL DISCUSSION

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

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

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

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

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

4. Should the Petitioner experience a change in circumstances, including a worsening of her condition, she can seek additional service beyond the Waiver limits. Should she experience a service reduction, the Respondent shall provide notice and an opportunity for a hearing.

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

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

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

I therefore find:

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

6. The Petitioner's mother provided attendant care services to the Petitioner. The parties are in agreement that the current payment rate for Attendant Care is $11.10.

7. The Petitioner's mother is entitled to reimbursement for the care that she provided as follows:

Hours for Which Petitioner's Mother Shall Be Compensated

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

CONCLUSIONS OF LAW

1. At all times during this appeal the Waiver provisions allowed the parents of adult children to serve as paid caregivers to those children according to their training and qualifications (Record of the 2009 Matter at 766.)

2. The rate specified for attendant care providers under the Waiver at all times during this appeal has been $11.10.

3. The Petitioner's mother shall be reimbursed by the Respondent in the amount of $140,148.60 for the care that she provided. The Respondent shall reimburse the Petitioner's mother within 30 days of the date of this Order.

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

DISCUSSION

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

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

CONCLUSIONS OF LAW

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

2. Changes to the pay rate which impact other attendant care providers will also be applied to the Petitioner's mother.

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

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

DISCUSSION

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

2. The Respondent shall reimburse the Petitioner's mother within 30 days of the date of this Order.

3. Whether the cost of the device is covered by the Waiver or by the State Plan is irrelevant to my decision and shall be determined by the Respondent and its agent, SCDDSN. That determination shall not impact or delay the reimbursement of the $8,318.80 owed to the Petitioner's mother.

4. This Order does not prevent the Petitioner from seeking the difference between the amount awarded here and the actual cost her family incurred. Nor does this Order prevent the Petitioner from seeking an assessment for a new speech generating device or a replacement speech generating device in the future. Should a future medical order for a speech generating device by the Petitioner's provider be denied or reduced by the Respondent, the Respondent shall send the Petitioner notice of such denial or reduction allowing the Petitioner the opportunity to appeal.

DECISION

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

2. The Petitioner's mother may provide some of the hours of care required under the Petitioner's Service Plan. If the Petitioner's mother provides such care, she shall be paid for that care at the rate for Attendant Care Services (currently $11.10 per hour).

3. The Petitioner's mother shall be repaid in the amount of $140,148.60 for the care she provided to the Petitioner during the pendency of this appeal. This amount shall be paid to the Petitioner's mother within 30 days of the date of this Order.

4. Within 30 days of the date of this Order, the Respondent shall reimburse the Petitioner's mother $8,318.80 for the cost of the speech generating device.

Any issues not addressed in this Order are deemed dismissed.

AND IT IS SO ORDERED.

Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina
November 19, 2013

SOUTH CAROLINA
Healthy Connections
MEDICAID

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

December 23, 2013

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

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

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

Dear Ms. Harrison and Mr. Hepfer:

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

Sincerely,

Elizabeth B. Hutto

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

EBH/ss
Enclosures (2)

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

BACKGROUND

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

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

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

(Respondent's Motion for Reconsideration at 4)

DISCUSSION

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

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

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

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

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

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

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

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

ORDER

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

AND IT IS SO ORDERED.

Elizabeth B. Hutto

Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina

December 23, 2013