

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS

Case No. 2013-002415

Brook Waddle,

~~Appellant~~, *Petitioner*

v.

South Carolina Department of Health and Human Services
Respondent.

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SC SUPREME COURT

APPENDIX VOLUME II

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Waddle v. DHHS

Volume II

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THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM THE SOUTH CAROLINA ADMINISTRATIVE LAW COURT

Honorable Ralph King Anderson, Jr.

Docket No.: 13-ALJ-08-0267-AP

 Brook Waddle,
Appellant,

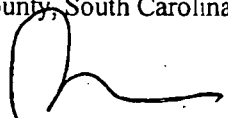
v.

South Carolina Department of Health and Human Services,
Respondent.

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NOTICE OF APPEAL

Brook Waddle appeals the order of Honorable Ralph King Anderson, Jr. dated and filed October 11, 2013 in Richland County, South Carolina, which was received by Appellant on October 15, 2013.



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November 11, 2013

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA

IN THE COURT OF APPEALS

APPEAL FROM THE SOUTH CAROLINA ADMINISTRATIVE LAW COURT

Honorable Ralph K. Anderson, Jr.

Docket No.: 13-ALJ-08-02670AP

Brook Waddle,
Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent.

CERTIFICATE OF SERVICE

I certify that I have served the Notice of Appeal on Shealy Reibolt and Honorable Ralph K. Anderson, Jr. By hand delivery on November 12, 2013 at the following addresses:

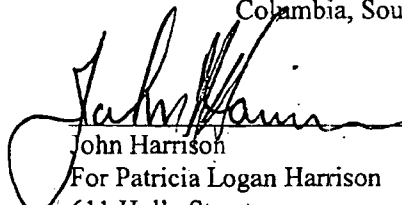
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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
IN THE STATE OF SOUTH CAROLINA

In the Court of Appeals

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

Case 2013-002415

Brook Waddle Appellant,

v

South Carolina Department of Health and Human Services Respondent.

INITIAL BRIEF OF APPELLANT

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SC Court of Appeals

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II.

Statement of Issues on Appeal

1. **Do Respondent's longstanding practices of failing to provide notices containing all of the information required by 42 C.F.R. 431.210 and dismissing Medicaid fair hearing appeals without providing evidentiary hearings, for reasons other than those reasons contained in the notices, violate participants' constitutional and statutory rights to due process and the Medicaid Act? Are these violations subject to repetition and have they evaded review?**
2. **Does the agency's practice of purging the record of evidence fair hearing appellants have submitted violate their constitutional and statutory rights to due process and is this violation is especially egregious when the agency dismisses an appeal without providing the required evidentiary hearing, where it would be required to accept such evidence into the record?**
3. **Have the Department of Health and Human Services (DHHS) and the Administrative Law Court violated the Separation of Powers Doctrine by obstructing review of Medicaid appeals by the Judicial Branch of government and administering the program based on arbitrary binding norms established by Executive Branch bureaucrats in violation of laws and regulations promulgated by the South Carolina General Assembly and Congress?**

III.

Statement of the Case

1. **Nature of the Case**

The parties have widely different views about the nature of this case. Appellant Brook Waddle alleges that this appeal is primarily about ongoing and systemic violations of her right to due process that is guaranteed her under the United States Constitution, the Constitution of the State of South Carolina and the Medicaid Act. Brook complains that DHHS has established a pattern and practice of sending defective notices, or not sending notices at all, and of dismissing fair hearing appeals without providing an evidentiary hearing, based on reasons other than those reasons contained on the notices. She alleges that these constitutional and statutory violations are subject to repetition, but they have evaded review, thereby obstructing her right to judicial review for years. Id.

Respondent views the case far more narrowly. On the one hand Respondent has argued that this case is solely about DHHS' decision to deny payment for an oximeter cable. R. ____.

Instead of supplementing the record of Brook's 2007 appeal (Docket No. 07-ALJ-08-0626-AP), as Brook requested when this subsequent violation occurred, Respondents treated her complaint as a totally new appeal, assigning the case a new number (Case No. 13-MISC-21). This new appeal is hereinafter referred to as "Waddle II." But, then DHHS filed a motion to dismiss the appeal with the Administrative Law Court, appearing to argue that it is part and parcel of Brook's 2007 appeal. The 2007 appeal is referred to herein as "Waddle I." R. ____.

The Administrative Law Court ruled that Brook's complaints about systemic violations of federal and state laws in Waddle I are irrelevant to this appeal. Both the agency and the Administrative Law Court dismissed her appeal without providing an evidentiary hearing.

2. The amount involved in the Appeal

Rule 208 of the South Carolina Rules of Appellate Practice requires the appellant to state the amount involved in the appeal. Because the hearing officer dismissed Brook's request for a hearing without providing the evidentiary hearing required by 42 U.S.C. 1396a(a)(3) and did not allow her to call or cross examine Respondent's witnesses or allow her to submit evidence at the required hearing, the Record does not contain the price of the oximeter cable. Appellant requests that this Court take judicial notice that Medicaid reimbursement rate for the device in our sister state of North Carolina is \$187.21. *See*

http://www.ncdhhs.gov/dma/fee/DME/dme_rates_0114.pdf. Although the device is inexpensive, the failure to use an oximeter can lead to death, thus, the value of this case is actually the value of the life of Brook Waddle. In *People v. Murray*, the conviction of Michael Jackson's personal physician for manslaughter was recently upheld by the California Court of Appeals, in part because the jury found that he failed to use an oximeter to properly monitor Mr. Jackson's vital signs. Case No. B237677 (Cal.Ct.Ap. January 15, 2014). ("According to expert medical testimony presented at trial using a proper pulse oximeter could have saved Mr. Jackson's life." *Id.* at fn 8.)

Instead of monetary damages, in her administrative appeal, Brook has requested nothing more than a declaratory order requiring DHHS to comply with the law and to stop violating the constitutional right to due process of Medicaid participants. Brook also requests that this Court order DHHS to pay reasonable legal fees and costs incurred in this civil action.

3. History of Brook's Medicaid Appeals

a. The April, 2007 Fair Hearing Appeal at DHHS

Brook filed an appeal in 2007 when DHHS refused to pay for the services and equipment her physician determined that she needed upon discharge from MUSC. She requested that all Medicaid services be continued during her 2007 appeal, as required by 42 C.F.R. 431.231. Since her discharge from MUSC in 2007, she has been receiving tracheotomy supplies through Medicaid. Instead of scheduling and holding an evidentiary hearing in 2007, the DHHS hearing officer issued an interlocutory order. R. _____. This order required Brook to submit a "Memorandum of Understanding" and that the Memorandum be in a form and content approved by DHHS. R. _____. But Brook was unable to reach an "understanding" with DHHS and resolution of the appeal was out of her control. R. _____. No such form existed. R. _____. Even though Brook notified the hearing officer that she had tried to comply with her order, instead of scheduling an evidentiary hearing, the hearing officer issued an "Order to Show Cause" on August 17, 2007. This order, issued more than 90 days after Brook filed her request for a fair hearing, required Brook to brief the issues in her appeal before the hearing officer would schedule an evidentiary hearing. R. _____. At this point, approximately 120 days had passed since Brook had requested a fair hearing. On November 16, 2007, the hearing officer issued an order dismissing Brook's fair hearing as "moot," over her objections, without providing the requested evidentiary hearing. 42 C.F.R. 431.244. R. _____.

b. First Appeal to the Administrative Law Court in 2007

Brook appealed the hearing officer's dismissal to the South Carolina Administrative Law Court in 2007. R. _____. In 2009, approximately two years after Brook requested a fair hearing, the Administrative Law Court reversed the agency decision and remanded Brook's appeal back to DHHS, with instructions to provide an evidentiary hearing. R. _____.

c. Fair Hearing Proceedings on First Remand from Administrative Law Court in 2009

The hearing officer held an all day "fair hearing" at DHHS on April 24, 2009 and issued an order on July 9, 2009, upholding the agency's decision to deny the services and equipment her doctor had ordered in 2007. R. _____. Order of DHHS Hearing Officer dated July 9, 2009.

d. Second Appeal to the Administrative Law Court in 2009

Brook filed a second appeal with the Administrative Law Court in 2009. As the appellant, Brook bore the expenses of having the hearing transcribed. Rule 35, Rules of the Administrative Law Court. After briefing, a hearing was held in the South Carolina Administrative Law Court on June 14, 2009 and another hearing held on March 1, 2010, but that Executive Branch Agency (the Administrative Law Court) - on the second trip to that court - did not issue a final administrative order until more than two years later. By that time, more than 1,800 days had passed since Brook filed her request for a final administrative decision requesting that needed medical care be provided with "reasonable promptness." During this time, DHHS improperly reduced Brook's services below the number of hours she was receiving in 2007 when she filed *Waddle I. B.W. v. DHHS*, Case No. 07-MISC-028 (SCDHHS Nov. 19, 2013).

This Court may take judicial notice that in 2012, according to the South Carolina Administrative Law Court's Annual Accountability Report for FY 2011-2012, that Court's "suggested time frame" for disposing of Medicaid appeals was 180 days. *See* http://dc.statelibrary.sc.gov/bitstream/handle/10827/9423/ALC_Annual_Accountability_Report_2011-2012.pdf?sequence=1 at 14. This amount is double the time allowed by federal law to issue a final administrative decision in a Medicaid hearing. 42 C.F.R. 431.244(f) and *Shakhnes v. Berlin*, 689 F.3d 244 (2d Cir. 2012). In FY 2012, the Administrative Law Court only ruled upon 40% of its Medicaid appeals within this 180 day period, taking an average of 284 days to decide Medicaid appeals. 2011-2012 Id. at 15. (This is in addition to the time Medicaid participants spend in the administrative proceedings at DHHS, and it does not take into account any prior appeal to the Administrative Law Court that was remanded back to DHHS.) CMS addressed the issue of delays resulting from remanding fair hearing appeals in the *State Medicaid Manual (SMM)*, which is a manual issued by CMS, the federal agency authorized by Congress to administer the Medicaid program. This 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" *Shakhnes v. Berlin*, 689 F.3d 244, fn 11 (2d Cir. 2012). The SMM states that "a

conclusive decision in the name of the State Agency shall be made by the hearing authority” and that a remand “is not a substitute for a definitive and final administrative action.” SMM § 2903.2(A).

Brook filed a motion to reconsider the Administrative Law Court’s decision to remand her case to DHHS and more time passed for a third round of oral arguments to be held in the Administrative Law Court. Appellant’s ALC Brief at 5. Instead of issuing an order that was appealable to the Judicial Branch, on July 30, 2013, the Administrative Law Judge again remanded Brook’s case back to the agency, with instructions to determine:

1. The weekly hours of registered nursing that are needed by the Appellant, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.
2. The specific type of care and the number of weekly hours of each type of care required by the Appellant during the course of her treatment since her discharge from the hospital in May of 2007 consistent with the Medicaid Program, and the principal that the mother is not legally responsible for caring for the Appellant.
3. The number of hours of the authorized care described in #2 above, that have been provided by the mother (according to her qualifications), and the cost of that care, which amount shall be paid to the mother.
4. The amount to be paid for services provided by Brook’s mother, requiring that her mother should be allowed to provide whatever care she is qualified to provide within the authorized hours of service.
5. The cost of an average digital speech device of the type described by Dr. Burton shall be determined and paid to the Appellant to defray the cost of the more expensive device.

R. ____.

e. Second Remand to DHHS in 2012

In October of 2012, an additional two days of evidentiary hearings were held at DHHS on remand from the Administrative Law Court. This hearing was presided over by Honorable Elizabeth Hutto, Esq., who was and is believed to continue to be the Program Director for the

DHHS Office of Appeals and Hearings.¹ On December 10, 2012, approximately 150 days after the most recent remand by the Administrative Law Court back to DHHS, and more than four years after Brook filed her appeal, in December of 2012, Brook filed "Petitioner's Motion for an Interlocutory Order," requesting an interlocutory order requiring DHHS to restore the hours improperly reduced since 2007 (which had been reduced in violation of federal regulations at 42 C.F.R. 431.231 and DHHS' own policies), reimbursement for the speech device in the amount DHHS had already agreed to pay (\$8,318.80) and partial payment to Brook's mother for services she provided for which Judge McLeod determined she was entitled to payment. R. _____. DHHS filed a response objecting to the requested interlocutory order, in part, because "a Final Administrative Decision...is no doubt imminent." R. _____. Yet, nearly a year passed before DHHS issued its order - while Brook's condition continued to deteriorate due to the refusal to provide even the hours she was receiving in 2007 when she filed Waddle I. More than six years after Brook requested a fair hearing complaining that the services her physician had ordered had not been provided with reasonable promptness, DHHS issued a decision on November 19, 2013. R. _____.

f. Appeal of Denial of Tracheotomy Supplies in 2013

In January of 2013, DHHS' agent, KePro sent Brook a notice informing her of the agency's decision to deny payment for an oximeter cable that she needs to measure the oxygen saturation level in her blood. R. _____ and ALC Order dated October 11, 2013 at fn 2. Like the other notices sent by DHHS, this notice did not contain the statute or regulations upon which the DHHS decision was based. Id. 42 C.F.R. 431.210. It also did not inform Brook of the procedure for appealing this denial. Id. Finally, the reason given for denying the prescription of Brook's physician eleven days after Apria submitted it to KePro was "Provider submitted no clinical information supporting request and prescription when requested to do so." Id. There is no evidence in the record that KePro or DHHS made any attempt to contact Brook's physician or to review the extensive medical records in the possession of DHHS to determine the medical

¹ In February of 2013, Ms. Hutto was appointed as the interim Deputy Director and Chief Financial Officer for DHHS, while continuing to hold the position as Program Director for the Office of Hearings and Appeals.

necessity for the device. On January 30, 2013, Brook requested that the record in her Waddle I appeal “be supplemented with this latest denial.” Id.

But, instead of treating this denial as further evidence of the ongoing and systemic violations that Brook complained of in her 2007 appeal, DHHS treated this information as a new and different appeal (referred to herein as “Waddle II”) and assigned it a new case number and hearing officer. R. _____. Instead of scheduling an evidentiary hearing and issuing a decision within 90 days, this new DHHS hearing officer issued a “Pre Hearing Conference Order” which required the parties to confer within one month and imposed a burden on DHHS counsel to file a “summary of issues discussed” and to inform the hearing officer “whether consensus had been reached and any remaining issues.” R. _____. The order required DHHS counsel to provide “with specificity, any additional information that will be submitted at the hearing...” and required Brook’s counsel to attend the conference and to file “a statement of intention to continue the appeal process and to attend a Fair Hearing.” But the order did not address the medical necessity of the device. Id. It did not mention the oximeter cable. Id. Brook’s counsel complied with that order.

On March 19, 2013, Brook’s counsel filed a three page document with the DHHS Office of Hearings and Appeals in response to that order, captioned “Appellant’s Response to Order.” In this Response, she indicated her intent to continue the appeal. R. _____. She incorporated and re-alleged all allegations made since 2007. In this Response, Brook requested reasonable accommodations during the hearing and she requested an independent medical assessment pursuant to 42 C.F.R. 431.240(b). R. _____.² Id. In the letter counsel for DHHS sent to the hearing officer in response to the Pre Hearing Conference Order, the agency admitted that the appeal arose from Apria’s denial of payment for an oximeter cable based on that DHHS provider (not Brook) failing to submit “supporting clinical information” to its agent, KePro. R. _____. Counsel for DHHS deferred to Brook “to allow her to submit to the hearing officer any additional issues

² DHHS paid the amount ordered for the speech device in January of 2013, but has appealed its own agency’s order requiring payment to Brook’s mother for services provided and it has refused to provide the number of hours ordered by the Director of the DHHS Office of Appeals and Hearings, who now also holds the position as Chief Financial Officer of DHHS.

she wishes to raise at the hearing.” Id.

On March 27, 2013, the hearing officer sent an email to counsel complaining that Brook’s Response “does not address the issue of my case (denial of prior authorization of an oximeter cable...)” (Emphasis added.) R. _____. The Pre Hearing Conference Order did not ask Brook to present proof of the medical necessity of the cable. The applicable federal regulations required that Brook be allowed to present testimony at an evidentiary hearing on that issue. 42 C.F.R. 431.242. Federal regulations at 42 C.F.R. 431.244(a) required the hearing officer to base her decision “exclusively on evidence introduced at the hearing.” In the email dated March 27, 2013, the hearing officer demanded that Brook provide her with written “documentation of medical necessity for the cable.” Brook asked in her formal Response that the hearing officer order a medical assessment, to be conducted at agency expense pursuant to 42 C.F.R. 240(b). Id. 42 C.F.R. 431.240(b) requires that this assessment be “obtained at agency expense and made part of the record.”³ Id. On April 4, 2013, the hearing officer issued an order dismissing Brook’s request for a fair hearing without providing an evidentiary hearing, concluding that Brook had somehow “abandoned the appeal...” by not providing written proof of medical necessity for the cable prior to a hearing being scheduled. R. _____.

g. Third Appeal to the Administrative Law Court in 2013

On May 9, 2013, Brook filed an appeal with the South Carolina Administrative Law Court of the dismissal of Waddle II, which had been dismissed by the DHHS hearing officer on the grounds of “abandonment.” Brook objected to the failure to provide an evidentiary hearing and the failure of the hearing officer to include in the Record on Appeal records of the 2007 appeal, which Brook had incorporated by reference in her Response to the hearing officer’s Pre Hearing Order.⁴ R. _____. In Issue 2 of Appellant’s Initial Brief filed with the Administrative Law

³ 42 C.F.R. 431.250(f) provides for federal matching funding for assessments authorized pursuant to 42 C.F.R. 431.240(b). The federal match in South Carolina is approximately 70%

⁴ It appears that the Administrative Law Court may have been under pressure to dispose of Medicaid cases more promptly than in the past. This Court may take judicial notice and compare that Court’s 2012-2013 Accountability Report to the prior year’s report, which shows that the average number of days to resolve a Medicaid appeal had increased from 284 days in FY 2011-2012 to 422 days by the following year. *See*

Court, Brook complained that:

DHHS and this Court, as agencies of the executive branch of state government, have violated the separation of powers provision of the South Carolina Constitution, Brook's Constitutional right to due process, her statutory right to notices of the denial, reduction or termination of Medicaid services meeting the requirements of 42 C.F.R. 431.210, her right to an evidentiary hearing meeting the requirements of 42 C.F.R. 431.242 and 244 and her right to a final administrative decision within 90 days of her April 28, 2007 appeal by failing to rule upon all of the issues raised in her 2007 appeal and delaying her opportunity for judicial review for more than six years.

On page 19 of Appellant's Initial Brief, Brook alleged:

The State Medicaid Agency has failed to provide an evidentiary hearing when her requests for services have been denied, in violation of 42 C.F.R. 431.220. DHHS and this Court have limited and interfered with her freedom to make a request for a hearing in violation of 42 C.F.R. 431.221. In clear violation of 42 C.F.R. 431.223, DHHS has dismissed Brook's requests for an evidentiary hearing. It has denied her procedural rights to an evidentiary hearing as established in 42 C.F.R. 431.242. (Emphasis added.)

Instead of simply providing this inexpensive device that is needed to measure Brook's oxygen saturation level, DHHS filed a Motion to Dismiss Brook's appeal with the South Carolina Administrative Law Court on September 11, 2013. R. _____. In this motion, DHHS asked the Administrative Law Court to dismiss Waddle II because her claim "is precisely or substantially the same in both proceedings."⁵ R. _____. Motion to Dismiss at 3. At that point,

<http://www.scalc.net/pub/FY2012-2013%20ALC%20Accountability%20Report.pdf>
http://dc.statelibrary.sc.gov/bitstream/handle/10827/12038/ALC_Annual_Accountability_Report_2012-2013.pdf?sequence=1 at 15. The number of Medicaid appeals had nearly doubled, increasing from 15 to 27 in just one year. Whereas in FY 2011-2012 forty percent of cases were resolved within the Court's own "objective" of 180 days between filing and disposition, a year later, only 23% of Medicaid appeals were being decided by the Administrative Law Court within 180 days. (These numbers do not include the time between the Medicaid participant filing her appeal with DHHS and the case being filed in the Administrative Law Court, nor are they believed to include prior appeals to the Administrative Law Court which were remanded back to DHHS). Dismissing Medicaid appeals, without providing a hearing, might have helped improve these statistics.

⁵ The November 19, 2014 order of the hearing officer in Waddle I did not mention the denial of the oximeter cable.

DHHS agreed with Brook that the violations complained of in Waddle II were “encompassed in the complaint” filed in 2007. *Id.* at 4. (“Therefore, Appellant’s appeal should be dismissed pursuant to Rule 12(b)(8) because the claims are precisely or substantially the same in both proceedings.” *Id.*)

h. DHHS Offer to Settle in 2013

While Waddle I and II were pending, in September of 2012, DHHS offered to settle Brook’s appeals by providing fewer hours than her physicians ordered since 2007, but more hours than are allowed by the current caps imposed on DDSN Medicaid waiver participants. November 19, 2013 Order at 10. But this offer would require Brook to abandon her challenge of the validity of the 2010 reductions, thus leaving her in worse shape than she was in when she filed her appeal in 2007. DHHS’ offer would restore the number of hours of services nearly to the level she was receiving in 2007, but would not provide the number of hours her physicians ordered now or in the future.

I. Administrative Law Court Order on 2013 Appeal (Waddle II)

On October 11, 2013, without providing a hearing in the Administrative Law Court, the Administrative Law Judge issued an order dismissing Waddle II. He found that the hearing officer erred in ruling that Brook had abandoned her appeal. Despite both parties now arguing that the denial of the oximeter cable was included in the appeal that had been pending since 2007, the Administrative Law Judge concluded that “the oximeter cable is a new claim that has not been raised in other, pending proceedings.” R. _____. His order dismissed Brook’s appeal (Waddle II) on different grounds, i.e. that Brook “failed to challenge the hearing officer’s decision in her Initial Brief.” *Id.*

j. Appeal of 2013 Administrative Proceedings to South Carolina Court of Appeals

Brook received the Administrative Law Court’s order dismissing her 2013 appeal (Waddle II) on October 15, 2013 and she filed and served a timely notice of appeal with the South Carolina Court of Appeals on November 12, 2014.

k. Third DHHS Order on 2007 Administrative Appeal (Waddle I)

Back at DHHS, on November 19, 2013, the hearing officer assigned to Waddle I (the action filed in 2007) issued an order on the 2007 administrative appeal. This decision confirmed

that DHHS had repeatedly over a period of years violated Brook's due process rights and that DHHS had improperly reduced her services during the appeal. R. _____. November 19, 2013 Order. The hearing officer ordered DHHS to provide the number of hours Brook's physician had ordered in 2007 during the pendency of her state administrative appeal, ordered DHHS to pay her mother for services that Medicaid should have paid and to reimburse Brook for a speech device that should have been provided in 2007. Id.

However, the hearing officer ruled that the Office of Appeals and Hearings does not have the authority to order DHHS to exceed the caps contained in the waiver document. R. _____. However, according to this order, the agency (DHHS) has the authority to exceed waiver limits "for this particular participant," at its discretion:

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.* (Emphasis added.)

Order dated November 19, 2013 at 31. This Court may take judicial notice that in *Peter B. v. Sanford*, 6:10-cv-00767-JMC -BHH, Report and Recommendation of Magistrate Judge dated November 24, 2010 (S.C.D.C. 2011) and in *Richard Stogsdill v. Sebelius*, Case No. 3:12-0007-TMC (SCDC), DHHS has argued that federal courts do not have jurisdiction over lawsuits brought by DDSN Medicaid waiver participants contesting the validity of these caps. DHHS has argued to those federal courts that the state administrative "fair hearing" proceedings are the sole remedy available. DHHS has also argued to the federal district court judge and the United States Court of Appeals for the Fourth Circuit in *Doe v. Kidd I and II* that the state administrative appeal process is the only remedy for Medicaid waiver participants who object to violations of federal law in the administration of Medicaid programs in South Carolina. *Supra*.

I. Third Appeal to the Administrative Law Court of the 2007 Appeal in 2013

Brook appealed the decision of the hearing officer, i.e. the decision that the hearing officer does not have the authority to exceed the caps imposed in 2010 (without authorization of the General Assembly or promulgation of regulations) to the South Carolina Administrative Law

Court in December of 2013.⁶ R. _____. If she had not filed this appeal, her services would have immediately been reduced below the amount her physicians and the hearing officer found to be inadequate to meet her needs.

Upon receipt of this November 19, 2013 order, HHS filed a motion to reconsider its own hearing officer's order in Waddle I and the hearing officer issued another order on December 23, 2013, affirming that the November 19, 2013 order was her "final order." R. _____ and _____. When the hearing officer issued the December 23, 2013 order on DHHS' motion to reconsider the November 19, 2013 order of the DHHS hearing officer, DHHS then filed an appeal of its own agency's final order with the South Carolina Administrative Law Court. _____ and _____.

m. Current Status

Brook requested additional time to file her brief in this Court after the issuance of the DHHS hearing officer's decision, hoping to negotiate a resolution. R. _____. That request was granted by this Court. R. _____. Unfortunately, the parties were unable to settle either appeal. The hearing officer, who had been promoted to the position of Chief Financial Officer for DHHS in February of 2013, while continuing to hold the position as Director of the Office of Hearings and Appeals, filed a request with the Administrative Law Court requesting an additional eight weeks to file the Record on Appeal in Waddle I. R. _____. The Administrative Law Court granted that motion to delay filing the transcript and the date for filing the Record on Appeal in Waddle I has been extended to April 3, 2014, nearly seven years after Brook filed her appeal and requested that medically necessary services be provided with "reasonable promptness." R. _____.

4. Proceedings in the lower court.

Rule 208 requires appellants to include in the Statement of the Case the proceedings in the lower court that have affected the appeal or may throw light upon the questions involved in the appeal. The pleadings the parties have filed and the orders of the agency and the lower court are included in Brook's Designation of the Record.

IV. Standard of Review

The standard of review in this case is governed by the Administrative Procedures Act.

⁶ Brook also alleges that a mathematical error was made in the calculation of the amount owed to Brook's mother for services she provided. R. _____.

S.C. Code Ann. § 1-23-380(5) (Supp.2010). *Jane Doe v. DHSS*, S.E.2d 605, 398 S.C. 62, 71 (S.C. 2011). This Court may affirm the agency's decision, remand the matter, or 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 granted of the agency;
- (c) made upon unlawful procedure;
- (d) affected by other error of law;
- (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
- (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Id. Brook seeks injunctive relief and a declaratory judgment in this action, not money damages. Declaratory judgments, in and of themselves, are neither legal nor equitable. *See Felts v. Richland County*, 303 S.C. 354, 356, 400 S.E.2d 781, 782 (1991). The standard of review for a declaratory judgment action is determined by the nature of the underlying issue. "Actions for injunctive relief are equitable in nature." *Shaw v. Coleman*, 373 S.C. 485, 492, 645 S.E.2d 252, 256 (Ct.App.2007). *See also* Jean Hoefer Toal, et al., *Appellate Practice in South Carolina* 193 (1999). In equitable actions, the appellate court may review the record and make findings of fact in accordance with its own view of a preponderance of the evidence. *Shaw at 492. See also Ingram v. Kasey's Assocs.*, 340 S.C. 98, 105, 531 S.E.2d 287, 290-91 (2000); *Townes Assocs. v. City of Greenville*, 266 S.C. 81, 85, 221 S.E.2d 773, 776 (1976).

The court may substitute its judgment for that of the agency on issues of law. *Mullis v. the South Carolina Department of Health and Human Services*, 04 ALJ 30-0194-AP (2005). While construction of a statute by an agency is accorded the "most respectful consideration," the final responsibility for the interpretation of the law rests with the Court. *Id.* "An agency's mistaken interpretation of a statute or regulation will constitute reversible error of law." *Id.* A reviewing court may reverse an agency's final decision as arbitrary if the decision is without rational basis, is based alone on one's will and not upon a course of reasoning and exercise of

judgment, is made at pleasure, without adequate determining principles, or is governed by no fixed rules or standards. *Id.* An abuse of discretion occurs where the deciding judge bases his decision on an error of law without evidentiary support. *Id.* at 475.

Statutory interpretation is a question of law that is subject to *de novo* review. *Town of Summerville v. City of N. Charleston*, 378 S.C. 107, 110, 662 S.E.2d 40, 41 (2008) (citation omitted). "The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature." *Media Gen. Commc'ns, Inc. v. S.C. Dep't of Revenue*, 388 S.C. 138, 147-48, 694 S.E.2d 525, 529 (2010) (quoting *Charleston Cnty. Sch. Dist. v. State Budget & Control Bd.*, 313 S.C. 1, 5, 437 S.E.2d 6, 8 (1993)). "If the statute is ambiguous ... courts must construe the terms of the statute." *Town of Mt. Pleasant v. Roberts*, 393 S.C. 332, 342, 713 S.E.2d 278, 283 (2011) (citation omitted). But, where the statute's language is plain, unambiguous, and conveys a clear, definite meaning, the rules of statutory interpretation are not needed and the court has no right to impose another meaning. *Gay v. Ariail*, 381 S.C. 341, 345, 673 S.E.2d 418, 420 (2009).

V. Background

1. The Medicaid Program

Medicaid is a federally funded program through which the federal government "provides financial assistance to states so that they may furnish medical care to needy individuals." *Jane Doe v. DHHS*, 398 S.C. 62, 727 S.E.2d 605 (S.C. 2011). Participation in the program is voluntary; however, participating states must comply with requirements imposed by the Medicaid Act and related regulations. *Wilder v. Virginia Hosp. Assoc.*, 496 U.S. 498, 502, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). ("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). To receive federal funding, a state must submit and have approved a "plan for medical assistance" that describes the nature and scope of the state's Medicaid program. *Id.* A state's plan must provide covered medical services with reasonable promptness to all Medicaid beneficiaries for whom they are medically necessary. See 42 U.S.C. § 1396a(a)(1), (a)(10)(A)(i), (a)(10)(B) (2006); *Doe v. Kidd I*, 501 F.3d 348, 354 (4th Cir. 2007) and *Doe v. Kidd II*, Case No. 10-1191 (4th Cir. March 24, 2011). When

DHHS denies, reduces or terminates services, or fails to provide services with reasonable promptness, DHHS is obligated to provide a evidentiary hearing meeting all of the due process requirements of *Goldberg v. Kelly*, 397 U.S. 254, 261(1970). 42 U.S.C. 1396a(a)(3) and 42 C.F.R. 431.200 et. seq.

In S.C. Code Ann. § 44-6-730, the South Carolina General Assembly directed DHHS to “promulgate regulations as are necessary for the implementation of this article and as are necessary to comply with federal law. In addition, the commission shall amend the state Medicaid plan in a manner that is consistent with this article.” S.C. Code Ann. (Emphasis added.) S.C. Code Ann. § 44-6-190 requires DHHS to promulgate regulations pursuant to the Administrative Procedures Act and directs that appeals from decisions by the department are heard pursuant to the Administrative Procedures Act, Administrative Law Judge, Article 5, Chapter 23 of Title 1 of the 1976 Code.

Agency policy is contained in the DHHS website which sets forth “Appeals and Hearings Frequently Asked Questions” at

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

This web page informs the public that the DHHS hearing officer “will decide whether the action proposed or taken by the South Carolina Department of Health and Human Services is correct and fair” and it informs the public that the hearing is “a court-like procedure conducted by a hearing officer of the Division of Appeals and Hearings.” DHHS explains that;

The hearing officer listens to your explanation of why you do not agree with the action taken by the South Carolina Department of Health and Human Services. The hearing officer will also listen to the South Carolina Department of Health and Human Services' explanation of the action taken on your case. Both sides can ask questions of any witnesses. The hearing officer will ask questions to get enough information to decide if your case was handled correctly, based on the current regulations and policies.

In keeping with 42 C.F.R. 431.210, this web page correctly states that the notice must contain the following information:

- (1) A statement of the proposed action
- (2) The reason for the proposed action
- (3) The regulation or policy that supports the action (see Regulations and Policy Links)
- (4) An explanation of your right to a fair hearing

(5) An explanation of how you can continue to receive benefits during the appeal process

This policy informs appellants that they must provide DHHS prior notice if they intend to be represented by an attorney at the hearing. (But DHHS does not impose this requirement to notify the appellant that an attorney will represent the department at the hearing.) According to this policy, appellants are informed that if they “withdraw or abandon” an appeal, their benefits will be discontinued. This policy describes “an Interlocutory Order” as is “a document sent to you and/or the South Carolina Department of Health and Human Services requesting additional action(s) or information.” DHHS informs appellants in this policy that DHHS may require them to attend a pre hearing conference and that if they do not respond to the Interlocutory Order by the due date, the hearing officer has the authority to dismiss the appeal. Appellants are also informed that a notice of hearing will be mailed at least 30 days before the hearing date. DHHS instructs appellants that DHHS may submit a brief, but that “Even if you do not give the hearing officer a brief, you can still make arguments, call witnesses, and submit documents at the hearing.” Evidence allowed into the record includes medical records, or school records” and “a letter from your doctor.”⁷ Documents may be submitted before or at the hearing. According to this agency policy, participants will be allowed to make an opening statement, present arguments and evidence, cross-examine the other party's witnesses and to present a closing statement. The fact sheet does not mention the requirement that DHHS issue a decision within 90 days, or that it must provide services with “reasonable promptness” (interpreted by the courts as meaning no later than 90 days).

When a Medicaid participant files a request for a fair hearing, it is the policy of DHHS to continue providing services on appeal until a final administrative ruling is issued by the Administrative Law Court. R. _____. Order dated Nov. 19, 2003 Order at 31. (“According to Dr. Veldheer, if a participant requests continuation of services, those services are continued through the Administrative Law Court level.” Id. at 26.) See also Affidavit of Byron Roberts, general counsel for DHHS attached to Brook’s December 10, 2012 Motion for an Interlocutory Order,

⁷ But this Court may take notice that DHHS has argued that sworn affidavits of health care providers should not be considered by hearing officers or considered as evidence, because they are “hearsay.” R. ____.

which states:

...if the DHHS Hearing Officer denies a Medicaid Waiver appeal, and the service recipient appeals that decision to the South Carolina Administrative Law Court, DHHS has a longstanding practice of keeping the services in effect during the pendency of the Administrative Law Court. Rule 34 of the Administrative Law Court Rules provides for an automatic stay of agency action during the pendency of an appeal to the ALC unless a party requests otherwise, but DHHS does not, as a practice, ask that the automatic stay be lifted in appeals involving service eligibility issues. This has been true for the administrative appeals...generally.

R. ____.

In addition to “regular,” or “State Plan” Medicaid benefits, the State provides Medicaid Home and Community Based services through the Head and Spinal Cord Injury (HASCI) program administered by the South Carolina Department of Disabilities and Special Needs (DDSN) under contract with DHHS. S.C. Code Ann. 44-38-310. This program was created by 42 U.S.C. § 1396n© (2000), allowing states to waive the requirement that persons with disabilities live in an institution in order to receive certain Medicaid services. *Doe v. Kidd I*, 501 F.3d 348, 351 (4th Cir. 2007). The Medicaid waiver program enables states to receive federal financial assistance specifically to provide medical care for needy individuals who would otherwise require institutional care. *Id.*

Prior to 2010, DHHS did not have caps on DDSN Medicaid waiver services, but drastic reductions were implemented on January 1, 2010, with caps imposed on the number of hours provided in the home. *Peter B. v. Sanford*, 6:10-cv-00767-JMC -BHH, Report and Recommendation of Magistrate Judge dated November 24, 2010 (S.C.D.C. 2011). R. ____.

Those caps were reversed by the Administrative Law Court in every known case in which the Medicaid waiver participant had a lawsuit pending in federal court when the Administrative Law Court issued its decision. When many of these “parallel track” waiver participants filed requests for an administrative hearing at DHHS, an “interlocutory order” was issued and their appeals were dismissed by the DHHS hearing officers without providing evidentiary hearings required by 42 U.S.C. 1396a(a)(3). Yet, while these administrative appeals were pending, after dismissal of their “fair hearing appeal” without providing an evidentiary hearing, DHHS continued to argue to the federal district court judges that the administrative appeal process was the sole remedy available to Medicaid participants and that the federal courts do not have jurisdiction to consider

complaints involving violations of the Medicaid Act. *Peter B. v. Sanford, supra., Hickey v. Forkner*, Docket No. 10-ALJ-08-0650AP (SCALC July 19, 2011).

In *Hickey v. DHHS*, the DHHS hearing officer dismissed the individual's fair appeal without providing an evidentiary hearing in 2010. R. _____. The South Carolina Administrative Law Court ruled that the DHHS hearing officer violated the participant's due process rights by dismissing Hickey's appeal without providing an evidentiary hearing and that the 2010 caps could not be enforced, because they established binding norms without promulgating regulations. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0650AP (SCALC July 19, 2011). In *Hickey v. Forkner* the federal district court issued an order prohibiting DHHS from applying the 2010 caps to reduce Hickey's services, allowing her to continue to receive 50 hours a week of PCA services - which is 22 hours a week over the cap established in 2010 by DHHS. Case No. 4:10-2696-TWL-TER (SCDC December 21, 2011). The federal court held that DHHS had improperly treated the 28 hour a week cap as a "binding and enforceable rule without promulgating the cap as a regulation pursuant to the Administrative Procedures Act." *Id.* The federal district court reported that DHHS informed the Court that it had no plan to promulgate the caps as a regulation. *Id.* DHHS has continued to treat these caps as binding norms for other Medicaid participants, in complete disregard for the ruling of the Administrative Law Court in *Hickey*.

The Administrative Law Court likewise, ruled that DHHS committed legal error by dismissing appeals in other cases based on Medicaid participant's responses to "interlocutory orders" without providing evidentiary hearings required by 42 U.S.C. 1396a(a)(3) in *Edge v. DHHS*, Docket No. 10-ALJ-08-0501-AP (SCALC October 29, 2010); *Eubanks v. DHHS*, Docket No. 10-ALJ-08-0502-AP (SCALC October 29, 2010); *Morgan v. DHHS*, Docket No. 10-ALJ-08-0503-AP (SCALC October 29, 2010).⁸ Yet, this same practice continues without corrective

⁸ In an order that conflicts with *Hickey*, in *Richard Stogsdill v. DHHS*, the hearing officer upheld the 2010 caps, despite DHHS having previously determined, in 2009, that more hours were medically necessary. R. ____, ____ and _____. (Orders of DHHS hearing officer and the Administrative Law Court in *Richard Stogsdill*). *Richard Stogsdill's* case is on appeal to this Court, with oral arguments scheduled for March 12, 2014. S.C. Court of Appeals Case No. 10-ALJ-0774-AP. The cuts were also recently upheld by the Administrative Law Court in *Myers v. DHHS*, 11-MISC-302(MR/RD) (SCDHHS February 9, 2012), in another order that contradicts *Hickey*. As in *Brook's* case, in *Myers*, the hearing officer first dismissed his case without

action in Waddle II and other cases.

In *Peter B. v. Sanford*, the district court granted the plaintiff's motion for a preliminary injunction, prohibiting DHHS from imposing the 2010 caps on Michelle M. and Chip E., which had not been promulgated as regulation. Case No. 6:10-767-TMC (D.S.C. March 7, 2013). R. _____. The South Carolina Administrative Court, adopted the holding in *Hickey*, ruling that the caps on DDSN Medicaid waiver services were unenforceable against Michelle M. and Chip E. *Eubanks v. DHHS*, Docket No. 10-ALJ-08-0502-AP (SCALC October 29, 2010); *Morgan v. DHHS*; Docket No. 10-ALJ-08-0503-AP (SCALC October 29, 2010). Yet DDSN and DHHS continue to enforce the caps against those Medicaid participants like Brook who have not yet filed federal lawsuits.⁹

providing a hearing, based on Myers responses to an "interlocutory order" that were unsatisfactory to the hearing officer. Id. On remand from the Administrative Law Court, the hearing officer upheld the reductions. Myers' case was frozen in the Executive Branch for four years before an opportunity for judicial review was made available to Myers on February 3, 2014, when the Administrative Law Court issued an order upholding the reductions. *Myers v. DHHS*, Docket No. 12-ALJ-08-0713-AP (SCALC Feb. 3, 2014). R. _____.

⁹ Subsequently, the federal district court dismissed the lawsuits brought by Chip E. and Michelle M., because they prevailed in their administrative appeals and DHHS assured the court that the caps would not be enforced against them. R. _____. *Peter B. v. Buschemi*, Case No. 6:10-767-TMC (D.S.C. 2012). Their attempt to appeal this interlocutory order was denied by the Court of Appeals for the Fourth Circuit, because the federal district court judge stayed the claims of the third plaintiff, Peter B., pending resolution of his state administrative appeal. The South Carolina Court of Appeals had remanded Peter's case to DHHS with instructions to provide a fair hearing "in accordance with this opinion and pursuant to 42 C.F.R. § 431.220(a)(1)-(2)." *Brown v. DHHS*, 393 S.C. 11, 709 S.E.2d 701 (S.C.App. 2011). But, in violation of that order of the South Carolina Court of Appeals, the DHHS hearing officer dismissed Peter's appeal again two years later, without providing a hearing on the merits of his case. *Peter Brown v. DHHS* (SCDHHS March 12, 2013). See also *Peter Brown v. DHHS*, Docket No. 13-ALJ-08-0159-AP (SCALC Feb. 4, 2014). The Administrative Law Court upheld that dismissal, over the objections of Peter's guardian in February, 2013. In *Peter Brown v. DHHS*, and in *Richard Stogsdill v. DHHS*, the DHHS Office of Appeals and Hearings purged from the record on appeal the testimony and evidence presented in the evidentiary hearings held in 2006 (Brown) and 2009 (Stogsdill). DHHS has not imposed the 2010 caps on Richard Stogsdill, solely because he has a pending lawsuit in the federal district court, and his services continue pending resolution of his federal case. The district court dismissed Stogsdill's claim against the federal government, allowing his private action against state actors to proceed. *Richard Stogsdill v. Sebelius*, No. 12-

The “comparability statute” of the Medicaid Act requires that services and eligibility requirements provided to one member of a covered group must be made available to all participants in that program. 42 U.S.C. § 1396a(a)(10)(B)(I), (ii). Services provided to any individual in a group of covered persons must be “equal in amount, duration, and scope for all recipients within the group.” 42 C.F.R. § 440.240. Courts have consistently recognized that states have violated the comparability requirement when some recipients are treated differently from other recipients in cases where each has the same level of need. *Schott v. Olszewski*, 401 F.3d 682, 688-89 (6th Cir.2005) (finding treatment was not comparable when Medicaid did not reimburse recipient for medical expenses she paid out of pocket after she was wrongfully denied coverage); *White v. Beal*, 555 F.2d 1146, 1151-52 (3d Cir.1977) (finding statute was illegal when it covered eyeglasses for those suffering from eye diseases but did not cover glasses for patients when refractive error caused poor eyesight).

Section 1320c, et seq. of the Social Security Act requires the creation of a peer review system developed through disinterested “Quality Improvement Organizations (QIO’s).” Quality Improvement Organizations review the activities of health professionals in the area “for the purpose of determining whether... the quality of such services meets professionally recognized standards of health care[.]” 42 U.S.C. § 1320c-3(a)(1)(B). QIO’s must “apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice within the geographic area served by the organization as principal points of evaluation and review, taking into consideration national norms where appropriate.” *Id.* at § 1320c-3(a)(6)(A). DHHS has contracted with KePro to provide QIO reviews. Because DHHS refused to provide an evidentiary hearing, where Brook could have called KePro and DHHS witnesses to testify, this Court should take judicial notice of DHHS’ website that announced its contract with KePro as its chosen “Quality Improvement Organization.”¹⁰ See

7, D. S.C.; 2013 U.S. Dist. LEXIS 18062 (S.C.D.C. Feb. 11, 2013).

¹⁰ The notice does not state whether Apria is a Managed Care Organization (MCO) and it does not advise Brook about how she can initiate an appeal. If Apria is a Managed Care Organization, the time frame for resolving her appeal is significantly reduced. 42 C.F.R. 431.244(f) provides that a decision must be issued “as expeditiously as the enrollee’s health

<https://www.scdhhs.gov/sites/default/files/QIOMedicaidBulletin.pdf>. According to its website at [/www.kepro.com/services/independent-medical-reviews.aspx](http://www.kepro.com/services/independent-medical-reviews.aspx), KePro is:

...dedicated to assuring that members are not unfairly denied medically necessary services. Our appeals are performed by independent, objective peer reviewers much like us who know the ropes. KEPRO performs fee-for-service and managed care appeals.

In Waddle II, there is no evidence of any review being conducted by peer reviewers at KePro before the DHHS hearing officer dismissed her appeal, over Brook's objections, without providing a fair hearing. The process KePro is supposed to follow was discussed in *In the Matter of Protests of Carolinas Center for Medical Excellence et al*, Case Nos. 2011-114, 115 and 116 (Richland County Chief Procurement Officer, June 21, 2011).

2. History of Brook's Medicaid Services

Upon discharge from the hospital in 2007, DHHS provided some services at home through both "regular" Medicaid and the HASCI program, pursuant to Brook's plan of care that DDSN approved. But DHHS denied Brook's request for payment for the number of hours and durable medical equipment that had been determined by her treating physician to be medically necessary. R. _____. November 19, 2013 Order. As the hearing officer recognized in her December 23, 2013 order, even though these services were inadequate to meet Brook's needs at home:

After many months of delays, the Petitioner was forced to accept Respondent's proposed hours if she wanted to return home. There was no viable alternative.

R. _____. DHHS also refused to pay for the speech device that had been ordered by two physicians. Id.

Brook is unable to move her arms or her legs, she breathes through a tracheotomy and

condition requires, but no later than 3 working days after the agency receives, from the MCO or PIHP..." 42 C.F.R. 438.410 contains rules for the resolution of expedited appeals:

(a) General rule. Each MCO and PIHP must establish and maintain an expedited review process for appeals, when the MCO or PIHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

suffers from grand mal seizures. R. ____ and ____ Id. at 1 and 15. She is fed by an attendant. She is afflicted by spastic quadriplegia, a neurogenic bladder, hypothyroidism, dysphagia, and hypotension. She has a history of pulmonary embolus and staff infections, including MRSA. Id. at 18 and 19. She has been hospitalized with confusion and an altered mental state and suffers from depression and anxiety. Id. at 18.

Brook must be suctioned throughout the day to clear mucus from her tracheotomy tube which "could be deadly ..." Id. at 14. Since returning home, Brook has suffered frequent bouts of pneumonia which require suctioning as frequently as three to five times an hour. Id. Brook requires catheterization and a bowel program and has suffered from frequent urinary tract infections and painful kidney stones. Id. at 15. Brook cannot feel when she is wet, causing her skin to break down. Id. Id. She has a history of decubitus ulcers and must be turned once or twice every two hours to prevent skin breakdown. Id. She needs, but is not receiving, physical therapy and occupational therapy to improve contractures which prevent her from straightening her arms. Id. Her skin breaks when her arms are stretched. Id. Brook takes daily medications for seizures, depression, neuropathy pain, prevention of muscle and bladder spasms and for migraine headaches. Id.

Waddle I has lingered in the Executive Branch for nearly seven years without a decision that is appealable to the Judicial Branch. More than 2,500 days have passed since Brook filed her 2007 administrative appeal complaining that DHHS was refusing to provide medically necessary services and equipment with reasonable promptness. Brook identified the following issues in her 2007 appeal:

1. The State's failure to provide Brook with services in the least restrictive setting, including, but not limited to, nursing services, attendant services, psychological services, assistive technology devices and other services for which appellant is eligible to receive. (Emphasis added.)
2. The State has failed to provide medically necessary services with "reasonable promptness."
3. The State erred in denying requested services in violation of applicable federal case law and regulations.

R. _____. In Waddle II, Brook alleged that DHHS' denial of the oximeter cable violated her right to due process and rights under the Medicaid Act. She has alleged that this action constituted evidence of continued violations of federal law that were appealed in Waddle I.

Brook testified at the 2012 hearing (through an affidavit, because she was unable to attend the hearing) that she would "rather die than go to a SCDDSN Regional Center like Whitten Center or to attend a workshop..." November 19, 2013 Order at 21. Ms. Hutto's order in Waddle I that was issued on November 19, 2013 determined that community based treatment is appropriate for Brook and that she requires "constant care and cannot be left alone." Id at 21 and 24. According to that order, Brook has not received the RN services that she needs. Id. The hearing officer ruled that Brook "should receive the maximum services available under the HASCI Waiver." Id. According to the order of the DHHS hearing officer in Waddle I, Brook 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." Id. at 25.

In one denial notice sent in 2007, DHHS informed Brook that the number of hours ordered by her physician exceeded HASCI limits. But this rule was contradicted in testimony from agency witnesses in Waddle I, because prior to 2008, DHHS did not impose caps on HASCI services. Id. at 7 and 9. In another notice, DHHS informed Brook that her request for services was being denied, because the cost would exceed the cost of nursing home care. R. _____. But, as the DHHS hearing officer stated in the November 19, 2013 order, according to testimony at Brook's 2012 fair hearing, "The HASCI Waiver Document is clear that there is no individual cost limit." According to the testimony of the director of the HASCI program, DDSN was following "limits we were applying at the direction of HHS," but no regulations were ever promulgated allowing either agency to limit Medicaid waiver services and no documentation of the basis for those limits appears in the record. Id. at 7.

In 2010, without promulgating regulations or obtaining approval of any kind from the South Carolina General Assembly, DHHS implemented "across the board" cuts in Medicaid waiver services. *Peter B. v. Sanford, supra.* and *Hickey v. Forkner, supra.* The hearing officer noted in the November 29, 2013 order that these reductions were implemented without providing an "individual assessment to determine whether the cuts were appropriate..." Id. at 10.

According to the current Chief Financial Officer for DHHS (hearing officer Hutto), no cost analysis was performed by DHHS to determine if less expensive services could be used and no medical review of the consequences of the cuts was performed by DHHS or DDSN. Id.

The DHHS hearing officer found that the notices DDSN issued to Brook in Waddle I “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.” Id. at 22. The November 19, 2013 order states that “the reasons for the denials given in these notices were erroneous according to the testimony of the Respondent.” Id. The hearing officer determined that Brook’s services were “improperly reduced several times” while her appeal was pending and that these reductions “occurred without notice and the opportunity to appeal.” Id. She ruled that DHHS improperly reduced Brook’s services in 2008 without providing the required notice. Id. The order states that DHHS again “improperly reduced” Brook’s hours in 2009 while her appeal was pending and that DHHS again “failed to provide proper notice.” Id. The order states that DHHS erred by failing to reassess her need for services when her parents divorced and her mother became Brook’s sole family caregiver. Id. at 23. She found that the DDSN service coordinator erroneously asserted that Brook was restricted to receiving two hours a day of RN services. Id. Because of “miscommunication and service reductions,” according to that order, Brook’s mother has provided all of the care that DHHS improperly failed to provide. Id.

Also according to the November 19, 2013 Order, prior to 2010, there was no evidence that the State conducted medical reviews of Brook’s condition to determine the number of hours of care that she requires. R. _____. Id. at 16. DHHS has not “provided any records which indicate that a physician for the Respondent has ever reviewed the Petitioner’s medical needs.” Id. at 24. Since 2010, a “centralized nurse” conducts an assessment to determine medical necessity, but this DDSN nurse has never met Brook nor been to her home. Id. at 16 and 17. The “centralized nurse” does not give any deference to physicians’ orders that exceed the caps DDSN has imposed. Id. The State failed to present any medical witnesses with “direct knowledge” of Brook’s condition at any of the hearings. DHHS’ medical director, Dr. Burton, was “somewhat familiar” with Brook’s case, but he never met Brook before the day he testified and he has no training in head or spinal cord injuries and he admitted that he was only “vaguely familiar” with

the HASCI program. Id. Dr. Burton admitted at the 2009 hearing that he did not have expertise to override the orders of a treating physician. Id. His decision to deny services was based upon "Department guidance and the SCDHHS provider manual policy." Id.

Even though the DHHS hearing officer ruled at page 25 that Brook's benefits "should have continued at the levels ordered by her treating physician during the pendency of this appeal," in violation of DHHS' policy, those services were repeatedly reduced and Brook has remained a captive in the Executive Branch Medicaid Appeal Gulag.

VI.

Arguments

1. **Do Respondent's longstanding practices of failing to provide notices containing all of the information required by 42 C.F.R. 431.210 and dismissing Medicaid fair hearing appeals without providing evidentiary hearings, for reasons other than those reasons contained in the notices, violate participants' constitutional and statutory rights to due process and the Medicaid Act? Are these violations subject to repetition and have they evaded review?**
- a. **The lower court's decision to deny payment for the oximeter cable should be reversed by this Court, because the DHHS notice was defective.**

In January, 2013, DHHS, through its agent, KePro, sent Brook a notice informing her of its decision to deny payment for an oximeter cable that she needs to measure the oxygen level in her blood. R. _____. It is clear on the face of the notice that it did not contain the statute or regulations relied upon - in violation of the clear and simple mandate contained in 42 C.F.R. 431.210. The notice also did not inform Brook about how she might obtain a hearing. The reason given for denying the oximeter cable was that "Provider submitted no clinical information supporting request and prescription when requested to do so." R. _____. There is no evidence that this decision to deny funding for an oximeter cable was based on the opinion of a physician or that KePro of DHHS reviewed the voluminous medical records available to DHHS or that any physician or nurse was consulted before denying payment for this inexpensive but life saving equipment.

The "fair hearing" notice requirements contained at 42 C.F.R. 431.210 are unambiguous and they are mandatory. The Supremacy Clause of the United States Constitution requires that DHHS comply with these regulations instead of the conflicting policies adopted by DHHS. The federal regulation at 42 C.F.R. 431.210 requires DHHS to provide in its notices of denial,

reduction or termination of Medicaid benefits both “the reasons for the intended action” and “the specific regulations that support, or the change in Federal or State law that requires, the action.”

There can be no doubt but that the South Carolina General Assembly directed DHHS to comply with federal law in providing notices to Medicaid participants. S.C. Code. Regs. § 126-380.

Denial, Termination, or Reduction of Benefits requires that:

A. When an individual's Medicaid benefits are denied, discontinued or changed, the individual shall receive notice pursuant to Title XIX of the Social Security Act. The notice shall include an explanation of the individual's right to a fair hearing, the method to obtain a hearing, and the right to representation.

42 C.F.R. 431.210(b) and (c).

The notice DHHS' agent, KePro, sent to Brook denying payment for an oximeter cable was clearly and plainly defective, because it did not contain the specific information required by 42 C.F.R. 431.210. It was legal error to deny payment for the oximeter cable based on this notice. This is a common practice for DHHS to ignore this federal notice mandate and Medicaid participants, including Brook, will continue to suffer unless this Court holds DHHS accountable for this violation and enjoins the agency from violating the law in the future, with appropriate consequences for contempt.

42 C.F.R. § 431.244(d) is meaningless if DHHS can notify the participant of one reason in the notice, then proceed to dismiss an appeal for a different reason not specifically allowed by the applicable federal rules. The “reason” KePro provided for denying payment for the oximeter cable Brook needed was that one of DHHS' providers failed to meet the agency's timeliness standards. The notice stated that KePro, had not received information it had requested from DHHS' provider, Apria, within 48 hours. R. 14. This “notice” did not even address or consider Brook's need for the equipment or the consequences of not receiving it. But, the hearing officer dismissed Brook's appeal based on reasons that were totally different from those reasons contained in the notice, which is a violation of 42 C.F.R. 431. 210. The actual reason the hearing officer used as grounds to dismiss Brook's appeal are that Brook did not comply to her satisfaction with an email she sent on March 27, 2013. That is not an allowable reason for dismissing an appeal and it was not included as grounds for dismissal in KePro's notice.

The federal regulations require DHHS to explain the circumstances under which a

hearing will be granted and how to continue benefits if an appeal is requested. 42 C.F.R. 431.210(d). The notice KePro sent on January 9, 2013 does not contain this information and it is facially deficient. DHHS should not be allowed to terminate a supply as important as an oximeter cable based on a defective notice that did not inform Brook of how she could continue to receive tracheotomy supplies while she fought the appeal.

Dismissing Brook's appeal on grounds not included in the notice directly conflicts with the federal regulation at 42 C.F.R. 431.223 which sets forth only two very limited grounds for dismissing an appeal (1) where the participant requests dismissal in writing, and (2) where the appellant fails to appear at a hearing without good cause. Not only did the hearing officer and the lower court allow the agency to violate 42 C.F.R. 210, the notice requirement, but their decision is in direct conflict with 42 C.F.R. 431.223. This violation of unambiguous requirement that the notice contain the reasons for the denial prejudiced Brook and violated her constitutional right to due process.

- b. **By dismissing Brook's appeal without providing a hearing, DHHS illegally denied her right of due process to be heard on her claims that DHHS had violated the Americans with Disabilities Act and the reasonable promptness mandate of the Medicaid Act.**

By dismissing Brook's appeal without providing an evidentiary hearing on her complaints, the hearing officer violated Brook's due process rights by failing to address or rule upon Brook's allegations that DHHS had violated the Americans with Disabilities Act. (Yet in the federal courts, DHHS argues that this is Brook's sole venue for addressing violations of the ADA.) The Hearing Officer failed to respond to Brook's allegations contained in "Appellant's Response to Order" alleging that the reductions in her services during the administrative appeals process violated agency policy and that DHHS had failed to rule upon her "emergency motion" that she had filed in December 2012.¹¹ R. _____. Brook alleged in her Response that the agency's

¹¹ At the hearing in 2012, DHHS argued that the reductions in services that occurred without notice in 2008 and 2009 were not properly before the hearing officer, because Brook had not filed new appeals addressing those reductions. Yet, when she raised this issue in what DHHS considered to be a new appeal in 2013, the hearing officer did not even address her complaint that DHHS had failed to act upon her request with reasonable promptness.

refusal to comply with the July 2010 order of the Administrative Law Court, the ADA and the Medicaid Act constituted "conscious indifference of DHHS and its officials to risks of harm to Appellant and the decline in her medical and psychological condition." R. at _____. The hearing officer also ignored Brook's requests that DHHS provide reasonable accommodations to allow her to participate in the fair hearing appeal. *Id.* She requested adaptive equipment that would allow her to participate in the hearing, which is required by the ADA, but the hearing officer ignored this request also by simply not scheduling a hearing. *Id.*

The hearing officer also ignored Brook's request for an independent medical assessment. Instead, the hearing officer illegally shifted the burden to Brook to provide a medical assessment, not just at the hearing, but to provide proof of medical necessity even before she would schedule a hearing. This is a clear violation of the mandate of the United States Supreme Court in *Goldberg v. Kelly*, 397 U.S. 254 (1970), which is specifically incorporated into the Medicaid regulations. 42 C.F.R. 431.202(b). The hearing officer exceeded her authority under the statute, these regulations and *Goldberg* by requiring written proof before scheduling a hearing and her decision was arbitrary and capricious and it was intended to harm Brook and to protect the agency.

These violations of Brook's due process rights have been repetitive, as is evident from the November 19, 2013 order, as well as dismissed appeals of Brown, Hickey, Edge, Eubanks, and Morgan. Brook and other vulnerable and powerless waiver participants have been prejudiced and they are likely to be subjected to these illegal acts again in the future and this Court should issue a strong rebuke by this Court and an order enjoining these Executive Branch agencies from future violations.

- c. **The hearing officer's decision to dismiss Brook's appeal without providing an evidentiary hearing must be reversed, because it violated the Supremacy Clause of the United States Constitution and Doe's right to due process.**

42 U.S.C. 1396a(a)(3) is unambiguous and it requires the State:

...to provide for granting an opportunity for a fair hearing before the State agency [responsible for the Medicaid program] to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness," §

1396a(a)(3).

Doe v. Kidd I, 501 F.3d 348, 357 (4th Cir. 2007). The due process standards which are set forth in *Goldberg v. Kelly*, and cited in the federal Medicaid regulations at 42 C.F.R. 431.202(d), require that " *the decisionmaker's conclusion ... must rest solely on the legal rules and evidence adduced at the hearing,*" and that " *the decision maker should state the reasons for his determination and indicate the evidence he relied on.* " *Goldberg*, 397 U.S. at 271.

The hearing officer erred as a matter of law in interpreting S.C. Code Ann. Regs. 126-154 as preempting federal law. The hearing officer's interpretation, i.e. that this state regulation allows a Department of Health and Human Services hearing officer to dismiss a Medicaid participant's administrative appeal without providing an evidentiary hearing is just plain wrong.¹² This was legal error because this state regulation is preempted under the Supremacy Clause of the United States Constitution by 42 U.S.C. 1396a(a)(3) of the Medicaid Act, which states that a State Plan for medical assistance must - (3) "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." In relying upon this state regulation that is preempted by federal law, the hearing officer and the Administrative Law Court failed to consider another DHHS regulation which correctly recognizes that federal Medicaid laws and regulations are controlling in this case and all Medicaid appeals. DHHS Regulation § 126-399, which is titled "Conflict Between State and Federal Regulations," provides that:

When the requirements of the State and the Federal regulations are not in agreement, the requirements of the Federal regulations shall prevail.

Federal law clearly and unambiguously required the hearing officer to base her decision

exclusively on evidence presented at an evidentiary hearing. 42 C.F.R. 431.244(a) provides that:

Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing.

¹² The hearing officer's "Findings of Fact" erroneously state that Petitioner's attorney failed to return a response to the "Pre Hearing Conference Order," thereby abandoning Brook's appeal. R. at 2 But, in response to that "Pre Hearing Conference Order," Brook's counsel filed and served a three page response on March 19, 2013. R. ____.

When a hearing officer fails to provide a fair hearing, it is impossible for her decision to be based exclusively on evidence presented at a hearing. As this Court has recognized, 42 C.F.R. 431.220(a) requires that “the State agency must grant an opportunity for a hearing to ... (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness, and (2) Any recipient who requests it because he or she believes that the agency has taken an action erroneously.” (Emphasis added.) *Brown v. DHHS*, 303 S.C. 11, 709 S.E.2d 701, 705 (S.C.App. 2011). (“Accordingly, the remainder of the order is vacated, and the case is remanded to DHHS for a hearing on the merits in accordance with this opinion and pursuant to 42 C.F.R. § 431.220(a)(1)-(2).”).¹³ Granting a hearing is mandatory, not optional...the federal regulations say “must,” not “may.”

The decision of the hearing officer and the lower court also ignores the mandate of federal law contained at 42 C.F.R. 431.205, which states that the Medicaid agency “must be responsible for maintaining a hearing system that meets the requirements of this subpart.” (Emphasis added.) That subpart requires that the State’s hearing system must provide for a hearing and that the hearing system “must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in this subpart.” In *Goldberg*, the United States Supreme Court ruled that the Due Process Clause of the Fourteenth Amendment to the United States Constitution requires an evidentiary hearing before government benefits can be terminated. The Court held that the appellant is not entitled to a trial, but she is entitled to an oral hearing before an impartial decision-maker, the right to confront and cross-examine witnesses, and the right to a written opinion that sets out the evidence relied upon and the legal basis for the decision. In *Goldberg*, as in Brook’s case, the government agency argued that allowing an appellant the opportunity to provide a written statement to “demonstrate why his grant should not be discontinued or suspended,” without providing an evidentiary hearing met the requirements of due process. *Id.* at 258. But, in declaring that procedure to be

¹³ But two years later, DHHS once again dismissed Brown’s appeal, over his objections, without providing an evidentiary hearing. *Brown v. DHHS*, (SCDHHS 2013) and (SCALC 2014). R. ____ and ____.

unconstitutional, the Supreme Court ruled that when "welfare is discontinued, only a pre-termination evidentiary hearing provides the recipient with procedural due process." Id. at 264. Brook was denied the right to a pre-termination hearing before funding for her tracheotomy supply, i.e. an oximeter cable, was denied.

As was the case with the plaintiffs in *Goldberg*, Brook "lacks independent resources" and her "situation becomes immediately desperate" when her benefits are reduced. Id. In *Goldberg*, the Supreme Court recognized that the welfare participant's "need to concentrate upon finding the means for daily subsistence, in turn, adversely affects his ability to seek redress from the welfare bureaucracy." Id. In dismissing Brook's appeal without providing the evidentiary hearing required by *Goldberg* and 42 C.F.R. 431.205, the lower court erred as a matter of law in failing to recognize that:

Public assistance, then, is not mere charity, but a means to "promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity." The same governmental interests that counsel the provision of welfare, counsel as well its uninterrupted provision to those eligible to receive it; pre-termination evidentiary hearings are indispensable to that end.

Id. at 265. As a hearing officer for the State Medicaid Agency, Ms. Johnson is charged with knowledge of the requirements of *Goldberg*, in which the Supreme Court directed:

It is not enough that a welfare recipient may present his position to the decisionmaker in writing or second-hand through his caseworker. Written submissions are an unrealistic option for most recipients, who lack the educational attainment necessary to write effectively and who cannot obtain professional assistance. Moreover, written submissions do not afford the flexibility of oral presentations; they do not permit the recipient to mold his argument to the issues the decisionmaker appears to regard as important. Particularly where credibility and veracity are at issue, as they must be in many termination proceedings, written submissions are a wholly unsatisfactory basis for decision. The second-hand presentation to the decisionmaker by the caseworker has its own deficiencies; since the caseworker usually gathers the facts upon which the charge of ineligibility rests, the presentation of the recipient's side of the controversy cannot safely be left to him. Therefore, a recipient must be allowed to state his position orally.

(Emphasis added.) The directive contained in 42 U.S.C. 431.244(a) comes directly from the directive of the United States Supreme Court in *Goldberg* that provides:

Finally, the decisionmaker's conclusion as to a recipient's eligibility must rest solely on the legal rules and evidence adduced at the hearing. *Ohio Bell Tel. Co. v. PUC*, 301 U.S. 292 (1937); *United States v. Abilene & S. R. Co.*, 265 U.S. 274, 288-289 (1924). To demonstrate compliance with this elementary requirement, the decisionmaker should state the reasons for his determination and indicate the evidence he relied on, cf. *Wichita R. & Light Co. v. PUC*, 260 U.S. 48, 57-59 (1922).

The hearing officer's March 27, 2013 email required Brook, after she had filed a three page response to the hearing officer's Pre Hearing Order, to prove to her in writing, before a hearing was even scheduled, that the oximeter cable was medically necessary. Brook had already responded to this hearing officer's "interlocutory order," by advising the hearing officer that she intended to participate in a fair hearing and that it would be legal error to dismiss her appeal, citing 42 C.F.R. 431. "unless the appellant requests dismissal or fails to appear at a scheduled hearing without good cause." R. _____. She requested that the hearing officer order an independent medical assessment and provide the hearing she was entitled to receive.

The hearing officer's decision to ignore this controlling Supreme Court case and the applicable federal statute and regulations was at very best arbitrary and capricious. In no uncertain terms, the Supreme Court directed government benefits agencies in *Goldberg* that: "Welfare recipients must therefore be given an opportunity to confront and cross-examine the witnesses relied on by the department." The facts that this is the second time a DHHS hearing officer has dismissed Brook's appeal complaining about DHHS' denial of services, without providing an evidentiary hearing, and the fact that this practice appears to be routine for the agency (as will be discussed in the issue addressing the violation of the Separation of Powers Doctrine) underscores the importance of a strong rebuke by this Court and an order requiring the Executive Branch agencies involved to comply with the United States Constitution and the requirements set forth by the United States Supreme Court in *Goldberg*.

The Supremacy Clause of the United States Constitution clearly preempts state regulations and requires DHHS and the lower court to comply with federal law. Instead, DHHS has repeatedly violated the clear requirements of 42 U.S.C. 1396a(a)(3) and CMS regulations contained at 42 C.F.R. 431.200 et seq. and their decisions must be reversed.

By dismissing Brook's appeal without providing an evidentiary hearing, the agency and

the lower court also violated the Fourteenth Amendment of the United States Constitution, which prohibits the States from depriving any person of life, liberty, or property, without due process of law. As the Administrative Law Court recognized in *Mullis I*: “Due process of law is one of the most important guarantees found in the United States Constitution.”¹⁴ *Supra*. Pursuant to Article I, Section 22 of the South Carolina Constitution. In *Mullis v. DHHS I*, DHHS terminated Mullis’ certification as a provider of DDSN waiver services in violation of her due process rights for two years before her eligibility was restored. 04 ALJ 30-0194-AP, Order dated March 22, 2005. R.

_____. In *Mullis*, the Court determined that the guarantee of due process contained in the Fourteenth Amendment of the Federal constitution prohibits the State from depriving any person of “life liberty or property, without due process of law.” *Mullis* at 10 or 15. Due process guarantees “basic fairness before a tribunal for all citizens.” *Id*. Fundamental to due process is the opportunity to be heard “at a meaningful time and in a meaningful manner.” *Mullis* at 10, citing *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965). But, as in Brook’s case, DHHS repeated this illegal process against Mullis several years later in complete disregard for the prior findings of the South Carolina Administrative Law Court in *Mullis v. DHHS II*, 10-ALJ-08-0775 (S.C.A.L.C. April 23, 2012). In the 2012 appeal, the Administrative Law Court again held that DHHS’ wrongful termination of Mullis’ contract was arbitrary and capricious, an abuse of discretion and that it was clearly erroneous in light of the reliable, probative and substantial evidence in the record.

In addition to the agencies violating the federal Constitutional rights of Appellant, SCDDSN has violated the state constitutional due process rights granted to Appellant in Article I, Section 22 of the South Carolina Constitution which provides:

No person shall be finally bound by a judicial or quasi-judicial decision of an administrative agency affecting private rights except on due notice and an opportunity to be heard; nor shall he be subject to the same person for both prosecution and adjudication; nor shall he be deprived of liberty or property unless by a mode of procedure prescribed by the General Assembly, and he shall have in all such instances the right to judicial review.

¹⁴ The patterns and practices of DHHS which violate the basic tenants of due process are found not only in the many cases DHHS has improperly dismissed without a hearing, but in two cases involving a provider of DDSN services whose due process rights were violated multiple times, without any attempt to correct the agency’s illegal practices. In *Mullis v. DHHS I*, DHHS improperly terminated her status as a provider of services in violation of her due process rights. 10-ALJ-08-0775 (S.C.A.L.C. April 23, 2012).

(Emphasis added.) This provision is specifically aimed at Administrative agencies such as DHHS. Lowell et.al, *South Carolina Administrative Practice and Procedure*, 2004 at page 47. In this case, substantial rights of Brook have been prejudiced by the agency's repeated violation of her constitutional and statutory due process rights to an evidentiary hearing before an impartial decision maker. S.C. Code Ann. § 1-23-380(5) (Supp.2010). Brook requests an injunctive order reversing the decision of the lower court and prohibiting DHHS from terminating any services or funding for durable medical equipment without providing an evidentiary hearing on the merits of her case. Brook requests an order reversing the decision of the agency and the lower court and requiring DHHS on all future appeals to comply with the due process requirements set forth herein. Brook requests an order finding that she is the prevailing party on this issue.

2. **Does the agency's practice of purging the record of evidence fair hearing appellants have submitted violate their constitutional and statutory rights to due process and is this violation is especially egregious when the agency dismisses an appeal without providing the required evidentiary hearing, where it would be required to accept such evidence into the record?**

Brook was prejudiced when the hearing officer dismissed her appeal and submitted an incomplete Record on Appeal to the Administrative Law Court. Brook requested in her Response to Hearing Officer Johnson's interlocutory order that allegations made "in the course of these proceedings and the appeal filed in 2007" be included in the record and those documents should have been included in the Record on Appeal. But, instead of providing an evidentiary hearing at which she would be allowed to submit this evidence of past wrongful acts, patterns of violation of due process and other testimony and evidence, as required by 42 C.F.R. 431.220, 431.240 and 431.244, the hearing officer dismissed her appeal and refused to include those documents in the Record on Appeal. The hearing officer purged Brook's carefully compiled record and did not include any of the testimony, pleadings and evidence that Brook had established at great cost during the six years she had spent in State Administrative Appeals Siberia. This practice of purging the record has been used by DHHS in other cases where DHHS refuses to include in subsequent Records on Appeal to the Administrative Law Court any of the evidence compiled before remand by the previous Administrative Law Court decisions. *Stogsdill v. DHHS* and *Brown v. DHHS, supra*. This is especially prejudicial to poor and disabled citizens like Brook who do not have funds to pay doctors and other health care providers to make repeated appearances or to prepare multiple declarations or affidavits on the same issue.

Medicaid participants are entitled to rely upon 42 U.S.C. 1396a(a)(3) and the regulations interpreting that act so that they do not end up at the Administrative Law Court with an inadequate record because the DHHS hearing officer violated the law and denied their right to introduce evidence and testimony at a hearing. 42 C.F.R. 431.244(b)(2) requires DHHS to include in the record "all papers and requests filed in the proceeding." South Carolina Rules of the Administrative Law Court require the agency to include in the Record on Appeal "All pleadings, motions, and intermediate rulings; all evidence received or considered; all proffers of proof of excluded evidence and the transcript of the testimony taken during the proceeding." By short circuiting this process, DHHS has violated Brook's right to have a complete record.

3. **Have the Department of Health and Human Services (DHHS) and the Administrative Law Court violated the Separation of Powers Doctrine by obstructing review of Medicaid appeals by the Judicial Branch of government and administering the program based on arbitrary binding norms established by DHHS bureaucrats in violation of laws and regulations promulgated by the South Carolina General Assembly and Congress?**

The South Carolina Constitution provides in S.C. Const. art. I, § 8 that : "In the government of this State, the legislative, executive, and judicial powers of the government shall be forever separate and distinct from each other, and no person or persons exercising the functions of one of said departments shall assume or discharge the duties of any other." In this case, the Executive Branch was required by federal law to issue a final order within 90 days of Brook's request for a fair hearing, after which the affected participant may seek judicial review. 42 C.F.R. 431.244(f), *Shakhnes v. Berlin*, No. 11-2003-cv (2d Cir. August 13, 2012) and *Doe v. Kidd I*, 501 F.3d 348 (4th Cir. 2007). The mandate that Congress imposed on the States to issue final decisions with "reasonable promptness" gives the Executive Branch 90 days to fix their errors. 42 U.S.C. 1396a(a)(3) and 42 C.F.R. 431.244(f), 42 C.F.R. 435.911. After that time, Medicaid participants are entitled to petition the Judicial Branch to review wrongful acts taken by the Executive Branch in administering the Medicaid program. This is especially important where life and death matters - like tracheotomy supplies - are at issue and a delay of years might result in death for want of an inexpensive device denied by DHHS.

DHHS and the Administrative Law Court, both agencies within the Executive Branch, have repeatedly violated the reasonable promptness standard of the Medicaid Act and they have attempted to prevent the Judicial Branch from reviewing their wrongful acts against the most needy, fragile, and vulnerable citizens of South Carolina. *Doe v. DHHS, supra* and *Brown v. DHHS, supra*. Through this system of delays and remands - administrative law keep away - persons like Brook may die before they reach the door of the court house.

As the South Carolina Supreme Court recently held:

The preservation of a separation of powers has been a basic tenet of democratic societies at least since Baron de Montesquieu warned that "[t]here would be an end of everything, were the same man or the same body, whether of the nobles or of the people, to exercise those three powers, that of enacting laws, that of executing the public resolutions, and of trying the causes of individuals." See Montesquieu, *The Spirit of Laws* 152 (Thomas Nugent trans. 1949). Consistent with this notion, the South Carolina Constitution requires the branches of government be "forever separate and distinct from each other, and no person or persons exercising the functions of one of said departments shall assume or discharge the duties of any other." S.C. Const. art. I, § 8.

South Carolina Public Interest Foundation and Sloan v. South Carolina Transportation Infrastructure Bank, 27266 (SCSC June 12, 2013). As the Court recognized in that case:

"One of the prime reasons for separation of powers is the desirability of spreading out the authority for the operation of the government." *State ex rel. McLeod v. Yonce*, 274 S.C. 81, 84, 261 S.E.2d 303, 304 (1979). "The legislative department makes the laws[,] the executive department carries the laws into effect, and the judicial department interprets and declares the laws." *Id.* at 84, 261 S.E.2d at 305. This delineation of powers amongst the branches "prevents the concentration of power in the hands of too few, and provides a system of checks and balances." *State ex rel. McLeod v. McInnis*, 278 S.C. 307, 312, 295 S.E.2d 633, 636 (1982).

In this case, these Executive Branch agencies have ignored both federal and state law and the intentions of Congress and the General Assembly. They have failed, or even refused, to promulgate regulations whereby the Legislative Branch would have an opportunity to review their procedures and policies and the public would have an opportunity to have input at public hearings.

Brook has been denied judicial review by the Executive Branch of government by these agencies' practice of cycling and recycling her case between state agencies by misusing the power of remand. The Executive Branch has totally ignored Brook's Constitutional and statutory right of due process and a final determination which must be issued within 90 days of the request for a fair hearing pursuant to federal regulations. *Doe v. Kidd I*, 501 F.3d 308 at fn 3. (4th Cir. 2007). These agencies have ignored 42 C.F.R. 435.930, which requires the State to "furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures." They have ignored the State's assurances made to CMS that "safeguards necessary to protect the health and welfare of recipients" will be provided. 42 C.F.R. 441.353.

42 C.F.R. 431.202(d) clearly provides that "The hearing system must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional

standards specified in this subpart.” But Brook has been denied, until now, the ability to have judicial review of these violations. DHHS and DDSN have violated the separation of powers prohibition by failing to promulgate regulations, as required by the South Carolina Administrative Procedures Act and by reducing, denying and terminating her services based on binding norms established by the agencies without promulgating regulations. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0650AP (SCALC July 19, 2011); *Edge v. DHHS*, Docket No. 10-ALJ-08-0501-AP (SCALC October 29, 2010); *Eubanks v. DHHS*, Docket No. 10-ALJ-08-0502-AP (SCALC October 29, 2010); *Morgan v. DHHS*, Docket No. 10-ALJ-08-0503-AP (SCALC October 29, 2010).

The Preemption Clause of the United States Constitution prohibits DHHS from dismissing Brook’s appeal without providing a fair hearing meeting the requirements of *Goldberg* and 42 C.F.R. 431.200 et. seq. and judicial review of agency actions. The United States Supreme Court recently addressed the issue of a State Medicaid Agency’s violation of the Preemption Clause of the United States Constitution. In *Wos v. E.M.A.*, North Carolina’s Medicaid Agency attempted to enforce a state Medicaid lien statute which conflicted with the anti-lien provisions of the Medicaid Act. 568 U.S. ___, (U.S. Supreme Court March 20, 2013). Justice Kennedy wrote in his majority opinion that “Where state and federal law ‘directly conflict’ state law must give way.” Affirming the decision of the Fourth Circuit, the Supreme Court ruled in *Wos* that:

Preemption is not a matter of semantics. A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute’s intended operational effect.

That is exactly what the Executive Branch of government has done in Brook’s case. Many of the provisions of the Medicaid Act are quite complicated and difficult to understand. The Act has been described as “an aggravated assault on the English language, resistant to attempts to understand it.” *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981). But, the requirements to provide a notice that meets the statutory provisions of 431.210 and the simple requirement to give every Medicaid participant who requests one a fair hearing and a final administrative decision within 90 days is not in any way complicated or difficult to understand.

42 C.F.R. 431.244(f) means something. According to the South Carolina Administrative Law Court’s Annual Accountability Report for FY 2011-2012, that Court’s “suggested time frame” for disposing of Medicaid appeals was 180 days, double the time CMS allows for a State to issue a final administrative appeal decision. See http://dc.statelibrary.sc.gov/bitstream/handle/10827/9423/ALC_Annual_Accountability_Report_2011-2012.pdf?sequence=1 at 14. 42 C.F.R. 431.244(f) and *Shakhnes v. Berlin*, 689 F.3d 244 (2d

Cir. 2012). That year, the Administrative Law Court only ruled upon 40% of its Medicaid appeals within this 180 day period, taking an average of 284 days to decide Medicaid appeals, not counting the time spent in proceedings at DHHS or earlier proceedings in the Administrative Law Court on the same issue. 2011-2012 Id. at 15. By the next year, the average length of time to decide a Medicaid appeal had increased to 422 days and only 23 percent of the Medicaid appeals were decided within 180 days. See Accountability Report for FY 2012-2013 at <http://www.scalc.net/pub/FY2012-2013%20ALC%20Accountability%20Report.pdf>. These numbers do not even include the number of days in DHHS “fair hearing” proceedings or in prior appeals of the same case to the Administrative Law Court.

CMS has addressed the use of remands to drag out administrative proceedings in the State Medicaid Manual (SMM), which contains CMS’ official interpretations of the law and regulations. This manual is binding on Medicaid State agencies and the Administrative Law Court. *Shakhnes v. Berlin*, 689 F.3d 244, fn 11 (2d Cir. 2012). The SMM states that “a conclusive decision in the name of the State Agency shall be made by the hearing authority” and that a remand “is not a substitute for a definitive and final administrative action.” SMM § 2903.2(A). Yet, these agencies have a long history of dragging out administrative appeals for years, flat out ignoring the reasonable promptness mandate, refusing to grant hearings on the merits and dismissing fair hearing appeals based on agency policy without complying with 42 U.S.C. 1396a(a)(3) or the unambiguous requirements set forth in 42 C.F.R. 431.424 and 244.

Brook prays for this Court to issue an order finding that the Medicaid “fair hearing” process violates the Separation of Powers Doctrine because it obstructs the timely review of denials of DHHS by the Judicial Branch and the reasonable promptness requirements of the Medicaid Act. The Executive Branch simply cannot comply with the mandates of federal law, which requires a final administrative decision to be issued within 90 days, under the current scheme. The current process requires the Medicaid participant to file an appeal with DHHS, which must provide at least 30 days notice prior to the evidentiary hearing required by 42 U.S.C. 1396a(a)(3). The agency has completely ignored 42 C.F.R. 431.244(f) by further delaying decisions through the issuance of “interlocutory orders” that violate *Goldberg* by requiring written proof instead of an evidentiary hearing. DHHS has flaunted its violations of Congress’ reasonable promptness mandate. Once the appellant reaches the Administrative Law Court, another Executive Branch agency, she must wait for DHHS to provide the Record on Appeal, which sometimes takes months. Then each side is allowed thirty days to file briefs with the Administrative Law Court and notice must be provided before a hearing can be held in that Court. Despite federal regulations which prohibit the Executive Branch from using remands to

delay a final decision, that is standard process in Medicaid appeals and Medicaid participants get sicker by the day, requiring more expensive treatment when their basic medical needs are ignored by the agency that has assured CMS that it will protect the health and welfare of Medicaid waiver participants.

This is a matter of extreme public importance. In order to qualify for Medicaid, in the DDSN Medicaid waiver programs in South Carolina, the participant cannot own more than \$2,000 in liquid assets. For every participant who makes it through the Herculean hurdles imposed by DHHS, then the Administrative Law Court there is a multitude of the most vulnerable citizens of our State who have no access to justice and no ability to navigate their way through the Executive Branch to the Courts of this State. Due process requires that these persons have access to the Judicial Branch. Not only do their lives hang in the balance, but taxpayers of this State are paying for expensive hospitalizations and institutionalization because Executive Branch agencies are denying funding for medically necessary services, like a simple oximeter.

VII. Conclusions

For the reasons set forth above, this Court should reverse the decision of the South Carolina Administrative Law Court and issue an order finding that the due process rights of Brook Waddle granted under the United States Constitution, the Constitution of South Carolina and the statutes discussed above have been violated. She requests an order reversing the decision of the lower court and requiring DHHS to pay for equipment necessary to care for her tracheotomy, including the oximeter cable ordered by her physician and other services in her approved plan of care. Brook requests a declaratory order requiring DHHS to include all contents described in 42 C.F.R. 431.201 in notices of adverse actions issued by DHHS or its agents and declaring that all notices issued by DHHS that do not contain all of the elements set forth in 42 C.F.R. 431.210 are null and void, requiring that the agency restore services and medical assistance in terminations or denials where defective or no notices have been provided, as required by 42 C.F.R. 431.231(c)(1).

Brook requests that this Court issue an order declaring that DHHS and its agents shall not dismiss any request for a fair hearing except where the appellant requests dismissal in writing or fails to appear at a scheduled hearing without good cause. Brook requests an order directing DHHS to address in a timely fashion (i.e. within 90 days of a request) all issues raised by appellants in requests for fair hearings where services are denied or not acted upon with reasonable promptness or where a hearing is requested because the appellant believes that the agency has taken an action erroneously. 42 C.F.R. 431.220(a)(2). She requests an order requiring DHHS to include in the Record on Appeal filed with the South Carolina Administrative Law

Court all records related to appellant's pending appeals in which a final administrative decision has not been issued, upon the request of the appellant.

Brook requests a declaratory order finding that the South Carolina Administrative Procedures Act, S.C. Code 1-23-380 requires judicial review upon exhaustion of administrative remedies and that a final Executive Branch decision must be issued within 90 days of DHHS receiving a request for a fair hearing, and that a remand by the South Carolina Administrative Law Court or DHHS "is not a substitute for a definitive and final administrative action." SMM § 2903.2(A). Brook requests an order declaring that S.C. Code 1-23-380 is not the sole remedy available to Medicaid participants and that the Administrative Procedures Act does not limit the scope of judicial review available under other means, including exercising her right to bring an action in federal court for violation of federal law.

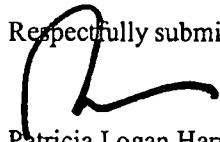
Brook requests that this Court declare that these Executive Branch agencies have violated the Separation of Powers Doctrine and requiring that a final administrative decision, appealable to the Judicial Branch, must be issued by the South Carolina Administrative Law Court within 90 days of a request for a fair hearing, except where the appellant requests an extension of time.

Brook requests an order directing DHHS to promulgate regulations for the administration of the Medicaid program, including Medicaid waiver programs administered by DDSN, and that the agency has acted without substantial justification in not previously promulgating regulations to carry out the program which do not conflict with federal law.

Finally, Brook requests that this Court declare that she is the prevailing party in this civil action and findings that the State has acted without substantial justification in this appeal, entitling her to legal fees. Brook requests directions on the correct procedure for filing a fee petition in this case.

Brook prays for such other relief as this Court shall determine to be necessary, just and proper.

Respectfully submitted,


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February 24, 2014

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED
MAR 10 2014
SC Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

Case No. 2013-002415

Brook Waddle Appellant,

v.

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

OBJECTION AND MOTION TO STRIKE

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

Pursuant to Rules 209(b), 210(c), and 240, SCACR, Respondent hereby moves to strike portions of Appellant's brief and Designation of Matter on Appeal which refer to and discuss documents and other materials not presented to or considered by the Administrative Law Court (ALC) or the hearing officer and which are irrelevant to this proceeding.

The ALC dismissed Appellant's case because it found she had not appealed the hearing officer's ruling that the appeal had been abandoned, making that ruling the law of the case. Previously, the issue before the Department of Health and Human Services hearing officer was the denial of prior authorization for an oximeter cable.

Appellant asserts a myriad of claims, citations, and documents in her brief and Designation of Matter on Appeal. However, much of Appellant's brief and Designation discuss and cite to documentation and authorities that were not presented to the lower courts and/or are irrelevant to this proceeding. Specifically, Respondent objects to and seeks to strike portions of Appellant's brief and Designation of Matter on Appeal for the reasons set forth below:

1. The parties are involved in a separate ongoing proceeding which began in 2007 regarding a speech generating device and Appellant's nursing and personal care hours, among other issues;
2. The appeal at issue involves the denial of prior authorization of an oximeter cable;
3. While Appellant has raised many of the same issues in this proceeding as the other proceeding, the oximeter cable at issue in this appeal was not included or a part of the other ongoing appeal;
4. Judge Anderson found that the only issue on appeal was the denial of the oximeter cable;
5. Judge Anderson found that additional documentation Appellant attempted to include in the Record on Appeal by attaching it to her initial brief to the ALC or by reference was not properly before the court;
6. Appellant has once again attempted to include information both irrelevant and not presented to the courts below in her brief and Designation of Matter on Appeal to this Court;
7. Discussions, references, citations, and documents relating to the separate ongoing

appeal are not properly before this Court as they are irrelevant to the disposition of the issue at hand;

8. Discussions, references, citations, and documents relating to the other ongoing appeal are not properly before this Court as they were not presented or not properly presented to the lower court;
9. Other cited documents and cases, including but not limited to the ALC's Annual Accountability Report and the CMS State Medicaid Manual, were not presented to the lower courts and are improperly raised for the first time to this Court.

Respectfully submitted,



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Columbia, South Carolina
March 10, 2014

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

Case No. 2013-002415

Brook Waddle Appellant,

v.

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

MEMORANDUM IN SUPPORT OF
OBJECTION AND MOTION TO STRIKE

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

Respondent hereby submits its memorandum in support of its objection and motion to strike portions of Appellant's brief and Designation of Matter on Appeal pursuant to Rules 209(b), 210(c), and 240, SCACR. Appellant's brief and Designation of Matter on Appeal refer to, cite, and attempt to incorporate documents and other materials that were not presented or not properly presented to the Administrative Law Court (ALC) or the hearing officer and/or are irrelevant to this proceeding.

I. Supporting Authority

Rule 209, SCACR, states that the Designation of Matter to be included in the

Record on Appeal “may only propose to include portions of the transcript, pleadings, orders, exhibits, or other materials which may be properly included in the Record on Appeal [See Rule 210(c)].” Furthermore, “[a] party shall not include any matter in his Designation which is not relevant to the appeal.” Rule 209(b), SCACR. Rule 210(c), SCACR, states, “The Record shall not, however, include matter which was not presented to the lower court or tribunal.”

In general, if an opposing party includes materials in the Record on Appeal which were not presented below, “it would be appropriate to make a motion to strike that matter.” This motion may necessitate remanding the appeal to the lower court for a determination as to whether the particular matter was presented. Procedurally, it is “prudent” to file a motion to strike upon receipt of the designations but before responding to the accompanying brief to avoid “unnecessary waste of time and expense” in amending the Record on Appeal at a later date. Toal, et al., *Appellate Practice in South Carolina*, 261 (2d ed.).

II. Procedural Background

This appeal arises from the dismissal of Appellant’s case by the South Carolina Department of Health and Human Services (SCDHHS) on April 4, 2013. The appeal involved the denial of a prior authorization for an oximeter cable. The hearing officer dismissed Appellant’s case for abandonment of the appeal and failure to respond to the hearing officer. See DHHS Hearing Officer Order.

Appellant filed a Notice of Appeal with the ALC on June 11, 2013, alleging a variety of claims. Chief Judge Ralph K. Anderson, III, dismissed Appellant’s appeal on

October 11, 2013, finding the only issue before the Court was the dismissal of Appellant's case regarding Respondent's denial of a prior authorization request for an oximeter cable. Judge Anderson dismissed Appellant's appeal because she failed to challenge the hearing officer's dismissal of her case for abandonment. Judge Anderson concluded that the determination that Appellant had abandoned her appeal was the law of the case. See Judge Anderson's Order, p. 8.

Notably, Judge Anderson's Order also discusses Appellant's attempt to reference and include arguments and materials "pertaining to a separate, ongoing proceeding" between the parties, including attempting to incorporate by reference allegations from the 2007 complaint and exhibits from the other proceeding into the Record on Appeal. Judge Anderson found the methods used by Appellant to introduce additional information into the Record on Appeal were not permitted by the ALC Rules, and those issues and documents were not properly before the court. See Judge Anderson's Order, pp. 6-7.

III. Portions of Appellant's Brief and Designation of Matter on Appeal Should Be Stricken Pursuant to Rules 209(b), 210(c), and 240, SCACR

As in her brief to the ALC, Appellant makes frequent and substantial reference in her brief to a separate, ongoing proceeding between the parties that began in 2007 and involves different issues than the denial of an oximeter cable. (See App.Br.pp. 1-2; pp. 3-6 (sections 3(a), 3(b), 3(c), 3(d), and 3(e)); p.7, lines 3-6, lines 18-19; p.8, lines 21-23; p.9, lines 1-10; pp.10-12 (sections k and l); p.21, lines 12-22; p.22, lines 18-29; pp.23-25 lines 1-7; p.27, lines 22-p. 28, line 3; p.34, lines 11-31 (section 2); pp. 35-39 (section 3), to the extent it refers to the other ongoing proceeding between the parties that began in

2007). Appellant states that her appeal of the oximeter cable “incorporated and realleged all allegations made since 2007.” (App.Br.p.7). Appellant references her attempt to incorporate a copy of the transcript and other documentation from the other pending action, including briefs and arguments from 2007, which are not a part of this proceeding. (App.Br.p.34). Appellant proposes to include documentation from the other pending proceeding in her Designation of Matter on Appeal as evidenced from her listing of “all pleadings, motions, orders and other documents filed in *Waddle v. DHHS* cases referred to in Brief.”

To the extent these references and documents refer to the separate proceeding between the parties, which involves issues such as a speech device and hours of nursing and personal care services, they were not presented or not properly presented to the lower courts in this matter. Moreover, they are irrelevant to this proceeding. Therefore, their discussion in Appellant’s brief and inclusion in the Designation of Matter on Appeal is improper, and those portions should be stricken.

Additionally, Appellant references and cites to other authorities or documents which are referenced for the first time in her brief and Designation of Matter on Appeal. For example, Appellant cites to the South Carolina Administrative Law Court’s Annual Accountability Report for fiscal years 2011-12 and 2012-13 and the CMS State Medicaid Manual, both raised for the first time in her brief to this Court, among others. The same is requested to be included in the Record in Appellant’s Designation of Matter on Appeal. As these documents and cases have not been presented to the courts below, it is improper for them to be included in Appellant’s brief or in the Designation of Matter on Appeal. Therefore, these portions should also be stricken.

To allow Appellant to supplement the Record on Appeal at this point with materials that were not presented to the lower court and/or are irrelevant to this proceeding prejudices Respondent. If the current briefing schedule is maintained, Respondent will be forced at this juncture of the appeal to research and draft responses to Appellant's newly presented claims and documentation that may ultimately be stricken by the Court of Appeals as improperly placed in the brief and Designation of Matter on Appeal. Respondent will also have been denied the opportunity to object to and address these issues earlier in the process, with particular concern for the materials which contain facts in dispute. Appellant's attempt to introduce new material at this stage violates the preservation principles key to appellate practice and prejudices Respondent by its inability to do the same. Allowing Appellant to raise issues from another pending case in this proceeding gives Appellant a second bite of the apple regarding the 2007 allegations and clouds the issues at hand in the current proceeding.

As the inclusion of the above-referenced information and documents in Appellant's brief and Designation of Matter on Appeal is erroneous, Respondent respectfully moves the Court of Appeals to:

1. Strike portions of Appellant's brief and Designation of Matter on Appeal which contain arguments, information, or material which have not been presented to lower courts, and/or are irrelevant to this proceeding about an oximeter cable;
2. Reschedule filing dates to allow Appellant to submit an updated version of her initial brief and Designation of Matter on Appeal which complies with any directions by the Court of Appeals to strike certain portions which were not presented to lower courts or are irrelevant;

3. Grant Respondent additional time in the rescheduled filing dates to respond to Appellant's corrected version of her brief and Designation of Matter on Appeal;
4. If necessary, remand this appeal to the ALC for a determination as to whether the matters presented in Appellant's brief and Designation of Matter on Appeal were presented or properly presented to the lower court.
5. Grant expedited review of Respondent's Objection and Motion to Strike due to the briefing schedule currently in place which requires Respondent to file its initial brief by March 26, 2014.

Respectfully submitted,



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Attorney for the Respondent

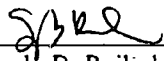
Columbia, South Carolina
March 10, 2014

CERTIFICATE OF MAILING

The undersigned hereby certifies that on this, the 10th day of March, 2014, I sent a copy of Respondent's Objection and Motion to Strike and supporting Memorandum to Appellant's counsel by U.S. mail with first class postage affixed, addressed to:

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

Respectfully Submitted,



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March 10, 2014
Columbia, South Carolina

RECEIVED
MAR 10 2014
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IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

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MAR 27 2014
SC Court of Appeals

Case No. 2013-002415

Brook Waddle Appellant,

v.

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

APPELLANT'S RESPONSE TO RESPONDENT'S MOTION TO STRIKE

What makes Respondent's motion so troubling, is that this is a case where the Respondent had a duty of care to the Appellant when DHHS denied payment for an oximeter cable and it has a continuing duty of care to Brook Waddle. *Madison ex rel. Bryant v. Babcock Center, Inc.*, 371 S.C. 123, 638 S.E.2d 650, 656 (S.C. 2006) and 42 C.F.R. 441.302 (States must provide CMS "Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services.) Instead of honoring that duty, Respondent again attempts to prevent the Judicial Branch from reviewing its actions. It is not unusual when dueling former spouses pull out all stops during litigation. Where a business owner is sued by a shopper who slipped and fell in a store, the business owner might be expected to mount an

aggressive defense against the plaintiff to whom she has no ongoing duty. But, Respondent's attempt here ignores the fact that in return for accepting 70% matching funding to administer the Medicaid program, DHHS agreed to comply with federal law. That is the *quid pro quo* - the deal DHHS agreed to accept. But, DHHS has acted as if it has no duty to provide due process to Brook Waddle or to other Medicaid participants. Congress made it unambiguously clear that its intent was not to give States free reign to ignore due process requirements established in the Medicaid Act, in federal regulations and by the United States Supreme Court in *Goldberg v. Kelly*, 397 U.S. 254 (1970). While the Medicaid Act does give States some discretion to limit care and services, within certain mandates contained in the Medicaid Act and the Americans with Disabilities Act, as a condition of accepting federal funds, the State is obligated to administer the Medicaid program "in the recipients' best interests." *Pharmaceutical Research and Manufacturers of America v. Walsh*, 538 U.S. 644, 665 (2003). 42 U.S.C. § 1396a(a)(19) provides that the State Medicaid plan must assure that care and services will be provided "in a manner consistent with . . . the best interests of the recipients".

As Respondent notes in its Motion filed in this Court, the general rule in appellate practice in South Carolina is that the Record in an appeal to this Court shall not include matter which was not presented to the lower court or tribunal. Page 2. First, Appellant did present the matter to which Respondent objects both to the hearing officer (by incorporating the 2007 appeal by reference) and to the lower court. Secondly, the South Carolina Rules of Appellate Practice provide exceptions to this general rule which may be applied by this Court in this case to do justice and to right a wrong that continues to threaten the very life of Brook Waddle.

In any event, Respondent has admitted that the issue of the oximeter cable is contained within the 2007 appeal. Brook draws this Court's attention to Respondent's motion to dismiss her appeal that was filed in the Administrative Law Court, instead of filing a brief in response to Appellant's brief filed in that Court. Exhibit 1. (Respondent's Motion to Dismiss filed in the Administrative Law Court). In that Motion, Respondent informed the Administrative Law Court that Brook's claim in the oximeter proceeding "*is precisely or substantially the same in both proceedings.*" Id. Respondent is bound by that representation to that court and it should not be allowed to change its position now that it wishes to prevent this Court from considering the long history of Brook's saga. The failure of DHHS to provide needed assistive technology devices was specifically included in the grounds of her 2007 appeal. Exhibit 2. Brook has shown that the "proceedings" in this matter include the appeal initiated in 2007, by incorporating by reference information from the appeal filed in 2007 in her Response to the hearing officer's interlocutory order. Exhibit 5.

Pursuant to federal law, the record in this case must consist of "All papers and requests filed in the proceeding." 42 C.F.R. 431.244(b)(2). DHHS was required to provide an evidentiary hearing at which the agency was required to give her an opportunity to "Establish all pertinent facts and circumstances" and to cross-examine the State's witnesses. 42 C.F.R. 431.242. Having blatantly violated 42 C.F.R. 431.244 and Brook's due process rights, now Respondent tries to prevent her from relying upon what information she put into the record before the illegal dismissal of her appeal.

Regardless, this Court may include the information at issue in the Record on Appeal at its

discretion. Rule 210(h), SCACR provides that "*Except as provided by Rule 212 and Rule 208(b)(1)© and (2)*, the appellate court will not consider any fact which does not appear in the Record on Appeal." (Emphasis added.) But those Rules clearly give this Court the authority to consider facts not contained in the Record that was prepared by DHHS and filed in the Administrative Law Court.¹ Brook respectfully requests a finding that she has demonstrated that this Court should justly apply Rule 212 and Rule 208(b)(1)(C) and request that the agency send all materials from the 2007 appeal to the Court for its review and consideration.

Rule 212, SCRAP authorizes this Court to "require copies of all or any part of the transcript of *proceedings or other matter* which was before the lower court or administrative tribunal to be sent up for inspection and consideration." This Court has the authority to "require a report of the trial or hearing, or of any matter relative thereto, to be made by the trial judge or administrative tribunal." Importantly, that rule provides that "These matters shall become part of the Record on Appeal." Brook prays that this Court exercise its authority under this Rule to require the agency to send up copies of the proceedings and all other matters before the lower court and administrative tribunal for this Court's inspection and consideration.

¹ In determining whether this is an appropriate case where Rules 212(a) should be applied, Brook asks this Court to consider that in most appeals, it is the Appellant who prepares the Record on Appeal, with the Respondent having an opportunity to object or to include additional records. But in Medicaid Appeals, not only is the hearing officer, who serves as judge and jury in these cases, allowed to determine what goes into - and is kept out of - the Record, the agency prepares and files the Record without input from the disabled person. While 42 C.F.R. 431.244(a) requires the hearing officer to base her decision "exclusively" and evidence presented at a fair hearing, in this case...and others...DHHS has simply ignored that federal law and dismissed appeals brought by Medicaid participants arbitrarily without providing an opportunity clearly required by 42 U.S.C. 1396a(a)(3) and federal regulations.

In addition, the information contained in Brook's initial brief should be allowed under Rule 208(b)(1)(C). Certainly the information she has provided on her seven year ordeal to receive medically necessary care at home "throws light upon the questions involved in the appeal." Rule 208(b)(1)(C). Respondent has the same right to respond by providing this Court with its own view of the information Brook has provided, pursuant to Rule 208(b)(2).

Respondent cries that it would be prejudiced by this Court considering the records Appellant has in good faith included in her initial brief. Having trampled on Brook's due process rights for years (as found by the DHHS hearing officer in *B.W. v. DHHS* at Exhibit 3), Respondent now argues that its own due process rights would somehow be improperly affected by this Court if its motion to strike is not granted. But this argument ignores the plain fact that Respondent, by its own illegal acts "denied [itself] the opportunity to object to and address these issues earlier in the process." 42 U.S.C. 1396a(a)(3) gave Brook the right to an evidentiary hearing. Other federal regulations interpreting that Act specifically required DHHS to administer the appeals process in compliance with *Goldberg v. Kelly* and other provisions contained in those regulations. *Supra*. DHHS had control of the proceedings and it chose to ignore the clear and unambiguous requirements of federal law requiring DHHS to hold a hearing at which the State could have presented whatever evidence it chose in opposition to Brook's appeal. 42 C.F.R. 431.244(a). Respondent's decision violated *Goldberg* and 42 C.F.R. 431.223 and the State comes to this Court with unclean hands. It is egregious for these state agencies (DHHS and the Administrative Law Court) within the Executive Branch to fight and violate federal law to prevent a hearing, then claim to be injured by the fact that no evidentiary hearing was held.

Appellant, having argued that the failure to pay for the oximeter cable was included

within the grounds contained in her 2007 appeal cannot now object to DHHS including evidence from the appeal filed in 2007. Thus, Respondent's argument that it is prejudiced by "its inability to do the same" is simply not convincing...and the agency is wrong here legally, ethically and morally.

Finally, Respondent asks this Court if it will not grant its request to strike, to throw Brook back into the abyss by remand to the Administrative Law Court. In her brief, Brook demonstrated that the Administrative Law Court's own 180 day aspirational standard for rendering a decision in Medicaid appeals is double the time allowed by federal law for the State to issue a final administrative decision. Federal law requires a 90 day standard of promptness to be met from the date of the request for the hearing at DHHS. 42 C.F.R. 431.244(f). The Court may take judicial notice of the Administrative Law Court's own Annual Accountability Reports documenting this violation of federal law.

An appellate court's right to take judicial notice of such facts is clearly established. As this Court recently recognized in *McCain v. Brighttharp* (399 S.C. 240, 730 S.E.2d 916, 920 (S.C.App. 2012) in *Bowen v. Green*, our Supreme Court took judicial notice that, generally, Baptist churches are governed by their own congregations. *Bowen v. Green*, 275 S.C. 431, 434, 272 S.E.2d 433, 434 (1980). Rule 201 of the South Carolina Rules of Evidence provides that judicial notice may be taken of adjudicative facts where the fact is "not subject to reasonable dispute in that it is either (1) generally known within the territorial jurisdiction of the trial court or (2) capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." In fact, those Rules provide that the court may take judicial notice,

whether requested or not. Id. It is mandatory for the court to take judicial notice “if requested by a party and supplied with the necessary information.” Id. Judicial notice may be taken “at any stage of the proceeding.” Id. The Annual Accountability Reports of the Administrative Law Court are certainly generally known within this Court’s jurisdiction and these reports are capable of accurate and ready determination. Certainly the Respondent is not suggesting that the accuracy of the Administrative Law Court’s Annual Reports is in question? As stated in Appellant’s brief, these reports are available to this Court and the public at

http://dc.statelibrary.sc.gov/bitstream/handle/10827/9423/ALC_Annual_Accountability_Report_2011-2012.pdf?sequence=1

and

<http://www.scalc.net/pub/FY2012-2013%20ALC%20Accountability%20Report.pdf>

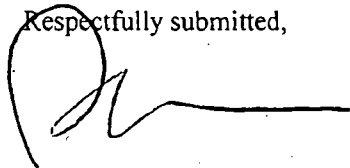
http://dc.statelibrary.sc.gov/bitstream/handle/10827/12038/ALC_Annual_Accountability_Report_2012-2013.pdf?sequence=1.

The reference to the CMS State Medicaid Manual recites language contained in a decision published by the Second Circuit in *Shakhnes v. Berlin*, 689 F.3d 244, fn 11 (2d Cir. 2012). That Manual, like the Administrative Law Court Annual Accountability Reports is generally known within this Court’s jurisdiction, as that Manual is published on CMS’ website and it is capable of accurate and ready determination to be accurate. It is the interpretation of the federal agency chosen by Congress to administer the Medicaid program and must be followed by DHHS, as a condition of participation in the Medicaid program.

Brook’s appeal has been pending now in the Executive Branch for seven years without an opportunity for review by the Judicial Branch of government. The agency and the

Administrative Law Court have each taken multiple bites at the apple, while Brook and her family have suffered and the agency has been allowed to act with conscious disregard for her medical needs and her right to due process. Meanwhile, Brook's condition has deteriorated significantly and her injuries are irreversible, yet the agency has consciously cycled and recycled her case between DHHS and the Administrative Law Court, preventing the Judicial Branch from reviewing their illegal Executive Branch practices. This Court has the authority to order DHHS to send up all documents contained in the 2007 appeal and Brook prays that it exercise this authority and that Respondent's Motion to Strike be denied.

Respectfully submitted,



Patricia L. Harrison
611 Holly Street
Columbia, South Carolina 29205
Phone: (803) 256-2017
Fax: (803) 256-2213
Attorney for Appellant

Columbia, South Carolina
March 24, 2014

List of Exhibits

- Exhibit 1. DHHS Motion to Dismiss filed in Administrative Law Court
- Exhibit 2. Appellant's Letter Stating Grounds for Appeal in 2007
- Exhibit 3. DHHS Hearing Officer Decision dated November 19, 2013
- Exhibit 4. DHHS Hearing Officer Decision dated December 23, 2013
- Exhibit 5. Appellant's Response to Order dated March 19, 2013

Exhibit 1

DHHS Motion to Dismiss filed in Administrative Law Court

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

B.W.,	)	
	)	
Appellant,	)	
	)	
v.	)	MOTIONS TO DISMISS OR,
	)	IN THE ALTERNATIVE,
South Carolina Department of Health and	)	PARTIAL MOTIONS TO
Human Services,	)	DISMISS
	)	
Respondent.	)	Docket No. 13-ALJ-08-0267-AP
	)	
	)	

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

Pursuant to Rule 38, SCALCR, and Rules 12(b)(1) and 12(b)(8), SCRCP, Respondent hereby moves to dismiss Appellant's appeal for: (1) Appellant's failure to file a timely Notice of Appeal in accordance with Rule 33, SCALCR; (2) lack of jurisdiction due to Appellant's failure to file her Notice of Appeal timely; (3) Appellant's stated intent to relitigate in this proceeding the same or substantially the same issues raised in a pending proceeding between the same parties. In the alternative, Respondent respectfully moves for dismissal in part of Appellant's claims on the same grounds as stated above.

This appeal arises from the dismissal of Appellant's case by the South Carolina Department of Health and Human Services (SCDHHS) on April 4, 2013. SCDHHS dismissed Appellant's case for abandonment of the appeal and failure to respond to the hearing officer. Appellant filed a Notice of Appeal with the Administrative Law Court (ALC) on June 11, 2013. A Notice of Assignment was issued on June 13, 2013.

FILED
SEP 11 2013

ADMINISTRATIVE LAW COURT

I. Appellant's Appeal Should Be Dismissed Pursuant to Rule 38

Rule 33, SCALCR, requires that the Notice of Appeal be filed "with the Court and a copy served on each party and the agency whose final decision is the subject of the appeal within thirty (30) days of receipt of the decision from which the appeal is taken." Appellant's Notice of Appeal would have been due for filing on or before May 9, 2013. The Notice of Assignment states the Notice of Appeal was received on June 11, 2013, more than thirty days after receipt of the hearing officer's Order.

Rule 38, SCALCR, states:

Upon motion by any party, or on its own motion, an administrative law judge may dismiss an appeal for failure to comply with any of the rules of procedure for appeals, including the failure to comply with any of the time limits provided by this section.

Therefore, Respondent moves that Appellant's appeal be dismissed for failure to comply with the Court's rules.

II. Appellant's Appeal Should be Dismissed Pursuant to Rule 12(b)(1), SCRCP, and Rule 33, SCALCR

A motion to dismiss filed under Rule 12(b)(1), SCRCP, alleging lack of jurisdiction is "purely a question of law for a court." See Woodard v. Westvaco Corp., 215 S.C. 329, 433 S.E.2d 8890 (Ct.App.1993). "Compliance with statutory time periods for filing appeals is a prerequisite for an appellate entity to have jurisdiction to hear an appeal." See Sheppard Construction Co., Inc. v. SCDHEC, 11-ALJ-07-0001-CC (March 28, 2011) (dismissing appeal pursuant to Rule 12(b)(1); SC Coastal Conservation League v. SCDHEC, 380 S.C. 349, 669 S.E.2d 899 (Ct. App. 2008) (reversed on other grounds by SC Coastal Conservation

League v. SCDHEC, 390 S.C. 418, 702 S.E.2d 246 (2010)); Hill v. SCDHEC, 289 S.C. 1, 698 S.E.2d 612 (2010). The South Carolina Supreme Court noted in Botany Bay Marina v. Townsend, 296 S.C. at 334, 372 S.E.2d at 586-87, that:

In Town & Country Civic Organization v. Winston-Salem Zoning Board of Adjustment, . . . the North Carolina Court of Appeals held that the Board's thirty day appeal period rule was binding and the plaintiff's failure to effect a timely appeal extinguished subject matter jurisdiction . . . Likewise, respondent's failure to appeal the Charleston County Board of Adjustment's decision to grant the zoning permits within fifteen days divested the Board of Adjustment of jurisdiction.

Rule 33, SCALCR, requires that the Notice of Appeal be filed with the Court and served on the parties within 30 days of the receipt of the decision from which the appeal is taken. As stated above, Appellant's Notice of Appeal would have been due for filing on or before May 9, 2013, but was not filed with the Administrative Law Court until June 11, 2013, more than thirty days after the receipt of the hearing officer's Order. The Administrative Law Court lacks jurisdiction due to Appellant's failure to file a Notice of Appeal within the designated time period. Therefore, Appellant's appeal should be dismissed pursuant to Rule 12(b)(1), SCRCP.

III. Appellant's Appeal Should be Dismissed Pursuant to Rule 12(b)(8), SCRCP

A motion to dismiss pursuant to Rule 12(b)(8), SCRCP, is proper when: (1) another action is pending; (2) between the same parties; (3) for the same claim. A motion to dismiss under this rule will be granted when a claim is precisely or substantially the same in both proceedings. Capital City Ins. Co. v. BP Staff, Inc., 382 S.C. 92, 674 S.E.2d 524 (Ct. App. 2009). Because each of the components of a Rule 12(b)(8) motion are determined as a

matter of law, a de novo standard of review is applied to determine the grant or denial of this motion. Capital City Ins., 382 S.C. at 100, 674 S.E.2d at 528.

In her Notice of Appeal and brief, Appellant makes frequent and substantial reference to an ongoing proceeding between the parties that began in 2007. Appellant goes so far as to state she is re-alleging claims in this proceeding that she has already made in the other pending action between the parties. Specifically, Appellant states, "The issues raised in this appeal are encompassed in the complaint Appellant filed with DHHS on April 28, 2007" (App.Br.p.1; p.15). Appellant's recitation of some of the issues in the other proceeding shows that they mirror the issues raised in this proceeding. (App.Br.p.4). Furthermore, in support of her same or substantially the same claims in this action, Appellant has included a copy of the transcript and other documentation from the other pending action and references briefs and arguments from 2007 which are not a part of this proceeding. (App.Br.p.15). As references in Appellant's Notice of Appeal and brief indicate, this appeal is "related to wrongful acts by DHHS occurring after the hearing which was held on October 30 and 31, 2012" and allegations that Respondent has failed to follow the ALC's order dated July 30, 2012. Appellant clearly refers to the previous and ongoing appeal between Appellant and Respondent and attempts to re-allege those same issues in this appeal.

The current proceeding involves two parties who are participating in another pending action for which Appellant has alleged the same or substantially the same claims. Appellant, per her own words, has re-alleged issues "encompassed in the complaint" filed in 2007, which are still being litigated in another proceeding. Therefore, Appellant's appeal should be dismissed pursuant to Rule 12(b)(8) because the claims are precisely or substantially the

same in both proceedings. Should this Court find that the issue of the dismissal without hearing regarding the denial of an oximeter cable is not substantially the same as claims in the prior proceeding, Respondent moves the Court grant a partial motion to dismiss in regard to Appellant's other claims that are precisely or substantially the same.

Respectfully submitted,



Shealy B. Reibold, Esquire
Assistant General Counsel
Department of HHS
Post Office Box 8206
Columbia, South Carolina 29202-8206
Phone: (803) 898-2792
Fax: (803) 255-8210
Attorney for the Respondent

Columbia, South Carolina
September 11, 2013

Exhibit 2

Appellant's Letter Stating Grounds for Appeal in 2007

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

TELEPHONE (803) 256-2017

FAX (803) 256-2213

28 April 2007

VIA FAX AND MAIL

Dr. Stanley Butkus
South Carolina Department of Disabilities and Special Needs
PO Box 4706
Columbia, South Carolina 29240

Acting Director
South Carolina Department of Health and Human Service
PO Box 8206
Columbia, South Carolina 29202

Mr. Vastine Crouch
Office of Appeals and Hearings
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, South Carolina 29202

RE: Brook Waddle

Dear Gentlemen:

By this letter, Brook Waddle is appealing the denial of services by the South Carolina Department of Disabilities and Special Needs and the South Carolina Department of Health and Human Services. We have delayed filing this appeal in hopes that these issues would be resolved within 30 days of DDSN's March 30, 2007 denial of nursing services. Unfortunately, these services are still not in place. During the course of this appeal, we are willing to work with both agencies toward returning Brook to her home community. However, we are requesting a final administrative determination within 90 days as required by 42 C.F.R. 431.244. Our grounds for appeal are as follows:

The State has failed to provide Brook Waddle with services under the Head and Spinal Cord Medicaid Waiver in the least restrictive setting, including, but not limited to, nursing services, attendant services, psychological services, assistive technology devices and other services for which appellant is eligible to receive. The State has failed to offer these services to Brook Waddle with reasonable promptness.

The State has failed to notify Brook Waddle of her eligibility for services under the MR/RD Medicaid waiver and to offer these services in the least restrictive setting with reasonable promptness.

The State failed to perform a PASARR assessment and specialized services as required by federal regulations prior to attempting to discharge Brook to an institutional setting.

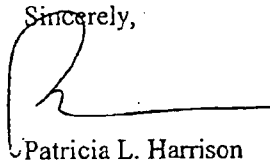
The State has failed to provide EPSDT services as required by the Social Security Act and federal regulations.

The State has improperly limited the hours of services offered to Brook Waddle in violation of the Social Security Act and Title 42 of the Code of Federal Regulations.

The State has acted erroneously in denying requested services in violation of applicable federal case law and regulations.

I have offered to meet with representatives from the South Carolina Department of Health and Human Services and the South Carolina Department of Disabilities and Special Needs and that offer remains open.

Sincerely,

A handwritten signature in black ink, appearing to be 'P. Harrison', with a long horizontal line extending to the right.

Patricia L. Harrison

cc: Brook Waddle
Ken Anthony, Esq.
David Zoellner, Esq.

Exhibit 3

November 19, 2013 order of DHHS hearing officer in B.W. v. DHHS

rec'd Nov 20, 2013
Pst



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,

A handwritten signature in cursive script that reads "Elizabeth B. Hutto".

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

EBH/ss
Enclosures (2)

Patricia Harrison Esquire

November 19, 2013

Page Two

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

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.

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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.	)	
_____	)	

JURISDICTION

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

BACKGROUND

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

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

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

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

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

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

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

The following documents were admitted as exhibits for the Petitioner:

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

6. Various DDSN Manual provisions;
7. A March 18, 2010, Discharge Summary from Greenville Hospital System;
8. The Service Coordinators' Record of Contact for the Petitioner dated for various times between 12/1/09 – 09/27/12;
9. DDSN HASCI Form 15 (9-10) dated 2/22/12 by Dr. Katherine Lumpkin;
10. ICD-9 Description of the E2510 Speech Generating Device;
11. Telephone Declaration of J. W. taken by Petitioner's attorney;
12. Telephone Declaration of B. W. taken by Petitioner's attorney;
13. Telephone Declaration of S. W. taken by Petitioner's attorney;
14. Affidavit of Don Kovach;
15. Declaration of Kathy Hoover, RN;
16. Attachments to Declaration of Kathy Hoover, RN;
17. Section 2 of the Home Health Services Manual, updated 10/01/12;
18. Section 2 of the Private Rehabilitation Therapy and Audiology Services Manual, update 10/01/12;
19. An August 20, 2010, News Release from the Comptroller General's Office about the budget challenges of FY 2010;
20. A May 8, 2009, cover letter enclosing documentation about the request for the speech generating device;
21. Affidavit of Lennie Mullis;
22. Packet of documents regarding the requested speech generating device;
23. Detailed Claims Report of Petitioner dated 10/16/2012;
24. Personal Care Needs Form, no date, for B.W.;

25. DDSN Annual Accountability Report, FY 2011-2012;
26. Document entitled Head and Spinal Cord Injury (HASCI) Waiver Recommendations for Revised Service Limits, Attachment D;
27. DDSN Service Coordination Manual, Revised July 1, 2011;
28. Documents from a Nursing Services Review of Petitioner by Vivian Koon; and
29. Photographs of Petitioner.

The following documents were admitted as exhibits for the Respondent:

1. Documents related to the original request for a speech generating device; and
2. The Current HASCI Waiver document.

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

ISSUES

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

1. The weekly hours of registered nursing that are needed by the Petitioner, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.
2. The specific type of care and number of weekly hours of each type of care required by the Petitioner during the course of her treatment since her discharge from the hospital in May of 2007 consistent with the Medicaid Program, and the principle that the mother is not legally responsible for caring for the Petitioner.

3. The number of hours of the authorized care described in #2, above, that has been provided by the mother (according to her qualifications), and the cost of that care, which amount shall be paid to the mother.
4. In the future, the mother should be allowed to provide whatever care she is qualified to provide within the authorized hours of service set as described in #2, above, and shall be paid for such services at a rate to be determined upon remand.
5. The cost of an average digital speech device of the type described by Dr. Burton shall be determined and paid to the Petitioner to defray the cost of the more expensive device she purchased.

HISTORY OF SERVICE HOURS DISPUTE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DISCUSSION

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

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 4

December 23, 2013 order of DHHS hearing officer in B.W. v. DHHS

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

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 5

Appellant's Response to Order

In the Office of Hearings and Appeals of
the South Carolina Department of Health and Human Services

RECEIVED

Fair Hearing of Brook Waddle v. DHHS

MAR 22 2013

Case No. 12-MISC-021 (MR/RD Waiver)

SCDHHS APPEALS

Appellant's Response to Order

Federal regulations contained at 431.243 provide that hearing decisions must be based exclusively on evidence introduced at the hearing and that a final determination must be issued within 90 days from the date the participant requested a fair hearing. Appellant has alleged that DHHS is in violation of federal regulations and has requested a fair hearing. An appeal may not be dismissed unless the appellant requests dismissal or fails to appear at a scheduled hearing without good cause.

The Appellant asserts that DHHS improperly denied equipment, supplies and services that are medically necessary. The agency has violated the requirements of the Medicaid Act that require DHHS to provide services in the amount, duration and scope necessary to prevent hospitalization and/or to delay or prevent institutionalization, that the agency has violated the reasonable promptness requirements of the Medicaid Act and that the failure to provide an appropriate speech device has prevented Appellant from communicating effectively with providers of health care and her attorney. All allegations previously made by Appellant during the course of these proceedings and the appeal filed in 2007 are herein realleged. In addition, DHHS has violated the Americans with Disabilities Act and the Rehabilitation Act of 1973 by failing to provide services necessary for Appellant to remain in the community and, thereby, placing her at risk of institutionalization. Respondent has violated the South Carolina

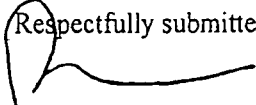
Administrative Procedures Act by failing to promulgate regulations for the operation of Home and Community Based Waiver programs.

Appellant filed an appeal in 2007, which has been remanded to this Office by the South Carolina Administrative Law Court twice, most recently in July of 2012. Six years has passed since this request for services was filed and seven months has passed since DHHS was ordered to comply with the findings of the South Carolina Administrative Law Court. During this appeal, in violation of its own policies, DHHS reduced the hours that have been ordered by Appellant's physicians and the agency has refused to pay Appellant for services provided by her mother or for the speech device her physicians determined to be medically necessary. An emergency motion was filed by Appellant in December, 2012, but no final order has been issued by the DHHS Office of Hearings and Appeals. Appellant's rights to due process have hence been violated and this violation is subject to repetition, yet it has evaded review. This refusal to comply with the Order of the Administrative Law Court, the Americans with Disabilities Act and the Medicaid Act has demonstrated conscious indifference of DHHS and its officials to the risks of harm to Appellant and the decline in her medical and psychological condition.

Furthermore, Appellant alleges that the agency has violated her due process rights by requiring her to attend any hearings in Columbia, by refusing to pay travel costs and costs of experts and by requiring Appellant to comply with requirements that are in excess of those contained in 42 C.F.R. 431 et. seq. Appellant requests that this Court provide reasonable accommodations to Appellant, as a person with a communications disability, as required by the Americans with Disabilities Act to enable Appellant to allow her to participate effectively in appeals before DHHS. Appellant requires adaptive equipment to enable her to understand and to be understood in any these proceedings.

This hearing involves medical issues concerning the needs of the Appellant, who requests the appointment of an independent medical assessment at the expense of the State, with this assessment to be scheduled at a time convenient to Appellant and her counsel. This response is being provided to the DHHS Office of Hearings and Appeals by email and regular mail.

Respectfully submitted,


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

March 19, 2013

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Case No. 2013-002415

Brook Waddle,

Appellant,

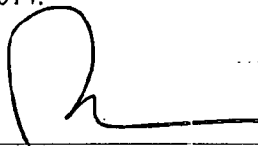
v

South Carolina Department of Health
and Human Services,

Respondent.

CERTIFICATE OF SERVICE

Patricia L. Harrison certifies that she has served *Appellant's Response to Respondent's Motion to Strike* in the above captioned case on the Respondent by United States mail to the Office of General Counsel, SC Department of Health and Human Services, PO Box 8206, Columbia, SC 29202-8206 on March 24, 2014.



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

RECEIVED

MAR 27 2014

SC Court of Appeals

The South Carolina Court of Appeals

Brook Waddle, Appellant,

v.

South Carolina Department of Health and Human
Services, Respondent.

Appellate Case No. 2013-002415

ORDER

This is an appeal from an October 11, 2013 order of the Administrative Law Court, affirming the dismissal of Appellant's appeal before Respondent. Respondent has filed a motion to strike Appellant's designation of matter to be included in the record on appeal and Appellant's initial brief. After careful consideration, Respondent's motion is granted. Within thirty days of this order, Appellant will file an amended initial brief and an amended designation of matter to be included in the record on appeal complying with the South Carolina Appellate Court Rules. See Rule 209(b), SCACR (noting the designation of matter to be included in the record on appeal "may only propose to include portions of the transcript, pleadings, orders, exhibits, or other materials with may be properly included in the Record on Appeal" and "A party shall not include any matter in his [d]esignation which is not relevant to the appeal"); Rule 210(c), SCACR ("The [r]ecord shall not, however, include matter which was not presented to the lower court or tribunal."). Because Respondent's initial brief and designation of matter is not due until after Appellant's brief and designation of matter is served, this Court declines to act on Respondent's motion for an extension.

 **FOR THE COURT**

Columbia, South Carolina



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

TELEPHONE (803) 256-2017

FAX (803) 256-2213

July 21, 2014

HAND DELIVERED

The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
1015 Sumter Street
Columbia, SC 29201

Re: Brook Waddle v. SCDHHS
2013-002415

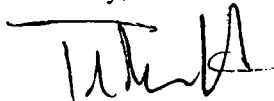
Dear Ms. Kitchings:

I am responding, although belatedly, to your letter dated June 4, 2014, after Mr. Wlodarczyk brought to my attention that a motion had not been filed as requested. I apologize. The documents identified in the Appellant's Brief are actually copies of unreported South Carolina cases which were attached to the Brief for the convenience of the Court. They should probably have been identified as "Unreported Cases," rather than Exhibits. The cases from the Administrative Law Court are available on their website and the South Carolina Bar's Casemaker website. The circuit court case is not reported and is, I believe, on appeal to your Court.

My understanding of Rule 208(b) was that it required permission to supplement the record with new facts, but that it does not require a motion to include unreported decisions. I have prepared a motion asking for permission to include these decisions as requested.

I apologize for any inconvenience and request instructions on how to proceed.

Sincerely,



Patricia Logan Harrison

c: Damon C. Wlodarczyk, Esq.

RECEIVED

JUL 21 2014

SC Court of Appeals

CERTIFIED SPECIALIST IN ESTATE PLANNING AND PROBATE LAW

THE STATE OF SOUTH CAROLINA
In the Court of Appeals
APPEAL FROM THE ADMINISTRATIVE LAW COURT
Ralph K. Anderson, III, Chief Administrative Law Judge

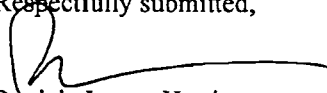
Case No. 2013-002415

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

MOTION

Appellant attached four unreported decisions from South Carolina courts as "Exhibits" to Appellant's Initial Brief. These decisions were attached for the convenience of the Court. Three of these decisions were from the South Carolina Administrative Law Court and one was issued by Judge Baxley, formerly of the South Carolina Court of Common Pleas. That decision, *T.R. v. South Carolina Department of Corrections*, 2005-cp-2925, is on appeal to this Court. If permission is required to include these decisions as exhibits or attachments, Appellant requests permission to attach the decisions to the Brief. If these decisions should be referenced differently in the Brief (as "Unreported Decisions" instead of "Exhibits") or not attached to the Brief, Appellant requests instructions. Appellant requests permission to make any changes to the Final Brief. Counsel attempted to communicate with opposing counsel by email. This Motion and the Certificate of Service are being hand delivered to the Court and opposing counsel.

Respectfully submitted,


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

July 21, 2014

RECEIVED

JUL 21 2014

SC Court of Appeals

The South Carolina Court of Appeals

Brook Waddle, Appellant,

v.

South Carolina Department of Health and Human
Services, Respondent.

Appellate Case No. 2013-002415

ORDER

Appellant's request to attach "four unreported decisions from South Carolina Courts as 'Exhibits' to Appellant's Initial Brief" is denied. *See* Rule 208(b), SCACR (providing a list of the content initial and final briefs may contain). Appellant's request to make the changes to the brief at the final briefing stage is granted. Appellant's final brief shall not include the "Exhibits."


FOR THE COURT

Columbia, South Carolina

cc:

Patricia Logan Harrison, Esquire
Shealy Boland Reibold, Esquire
Kenneth C. Anthony, Jr., Esquire

FILED

9/5/14

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SOUTH CAROLINA
Administrative Law Court

Ralph King Anderson III, Administrative Law Judge
Trial Court Case No.: 2013-ALJ-080267-AP

Appellate Case No.: 2013-002415

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SC Court of Appeals

Brook Waddle,.....Appellant,

v.

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

RESPONDENT'S MOTION TO DISMISS APPEAL

**SOUTH CAROLINA DEPARTMENT
OF HEALTH AND HUMAN SERVICES**

SHEALY BOLAND REIBOLD
1801 Main Street, Suite 1100
Columbia, South Carolina 29201
(803) 898-2791 - Office
Counsel for the Respondent

RILEY, POPE & LANEY, LLC

DAMON C. WLODARCZYK
P.O. Box 11412
Columbia, South Carolina 29211
(803) 799-9993 – Office
(803) 239-1414 – Facsimile
damonw@rplfirm.com
Counsel for the Respondent

FACTS

Respondent ("DHHS") hereby submits its Motion to Dismiss pursuant to Rule 240 of the South Carolina Appellate Court Rules and shows this Honorable Court the following:

Appellant ("Waddle") was injured in an automobile accident in 2005, which rendered her quadriplegic. Following the accident, Waddle became a Medicaid-eligible individual, who has been receiving services under the South Carolina Head and Spinal Cord Injury ("HASCI") waiver program. Under the waiver program, participants can receive a mix of services through the South Carolina Department of Disabilities and Special Needs ("DDSN"). Waivers are mechanisms within the Medicaid program under which, by having certain generic requirements of the Medicaid program "waived," States are able to provide services to eligible participants in ways not allowed under the regular Medicaid program. This waiver and other waiver programs operated by DDSN are for home and community based services under Section 1915(c) of the Social Security Act. 42 U.S.C. § 1396n(c). These types of waivers allow services to be provided in the home or community in lieu of institutional services. DDSN is responsible for the day-to-day operations of the waiver program, but DHHS is the single agency responsible for the South Carolina Medicaid program. [Order on Appeal, pp. 1-2].

Apria Healthcare, Inc. ("Apria"), is a provider of durable medical equipment ("DME"). Apria submitted to KePro, an agent of DHHS, a prior authorization request on behalf of Waddle for a piece of DME, specifically requesting an oximeter cable which measure that oxygen saturation of the blood. However, the request was denied

because Apria did not provide any supporting clinical information with the request. Both Waddle and DHHS attempted to resolve the issue without success. [Id., p. 2].

On January 31, 2013, Waddle filed an appeal of the denial of the oximeter cable to DHHS's Division of Appeals and Hearings. On April 4, 2013, the agency hearing officer issued an Order dismissing Waddle's appeal on procedural grounds. [Id., p. 3]. Waddle appealed the Order dismissing the appeal to the Administrative Law Court ("ALC"), which affirmed the procedural dismissal in an Order dated October 11, 2013, which is the subject of this appeal. The ALC noted in the Order that, as of March 19, 2013, "there is nothing in the Record on Appeal to indicate that the issue has since been resolved." [Id., p. 2 at footnote 4].

ANALYSIS

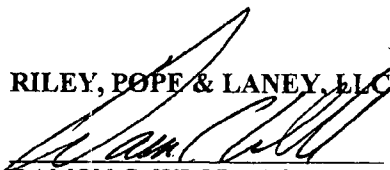
Generally an appellate court "will not pass on moot and academic questions or make an adjudication where there remains no actual controversy." Sloan v. Dep't of Transp., 379 S.C. 160, 167, 666 S.E.2d 236, 240 (2008) (internal citations omitted).

As evidenced by the Affidavit attached hereto as Exhibit 1, if the proper code to request an oximeter cable is used by the ordering healthcare provider, the equipment should be approved without the necessity of prior authorization. [Exhibit 1]. In the present case, the healthcare provider, Apria, incorrectly coded the request for the oximeter cable and, therefore, the request was denied. However, the coding issue was discovered when the denial was appealed and the cable was approved manually and Waddle received the cable. Moreover, if the correct code is used by the provider in the future, barring any other error, it will be approved without prior authorization. [Id.].

Based upon the fact that the coding error was identified and the DME provided to Waddle, the issue on appeal is moot. Even if Waddle prevailed in her appeal to this Court, the relief would be to remand the matter to DHHS's Division of Appeals and Hearings for a fair hearing to determine whether or not the denial of the oximeter cable was proper, and whether or not the DME should be provided to Waddle. As DHHS has resolved the issue and provided the oximeter cable to Waddle, and DHHS has indicated that absent any future coding error the oximeter cable will continue to be provided without prior authorization, there is no need for a fair hearing or relief that the fair hearing officer could provide. As such, the present appeal should be dismissed as moot as there remains no actual controversy.

CONCLUSION

For the reasons set forth herein, DHHS respectfully requests that the Court dismiss with appeal as moot.


RILEY, POPE & LANEY, LLC

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Counsel for the Respondent

Columbia, South Carolina
November 24, 2014

STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND)

AFFIDAVIT

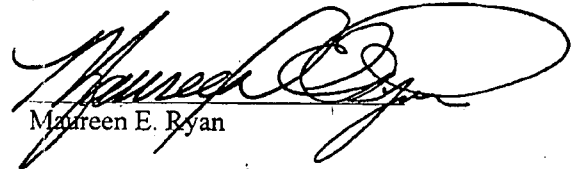
Personally appeared before me Maureen E. Ryan, who being duly sworn deposes and says as follows:

1. That she is a Program Coordinator II in the Division of Health Services of the South Carolina Department of Health and Human Services (SCDHHS);
2. That, in her position she drafts and publishes the policy which sets forth the method by which requests for oximeter cables and other durable medical equipment (DME) are processed, including for participants of the Medicaid Waiver Programs managed by the Department of Disabilities and Special Needs (DDSN) for the SCDHHS;
3. That, once the need for such a cable by an adult Waiver participant is identified, arrangements should be made for the participant to see a Medicaid-enrolled DME provider in order that a request for the product or accessory may be certified as medically necessary and submitted by the provider to the Medicaid agency;
4. That, all such requests, along with the initial certification of medical necessity are sent by the provider to the SCDHHS Office of Claims, Operations and Provider Relations, where they are again reviewed and, if proper, are approved to be supplied by the provider;
5. That, although the individual is in a Waiver administered by the DDSN, the equipment would be requested, processed, and paid through the regular Medicaid Program;
6. That, the proper code by which to request an oximeter cable is A4606, and if this code is used by the ordering healthcare provider, this code should be approved without the necessity of a prior authorization;
7. Upon researching this issue, it appears that previously, for this Participant, B.W., Medicaid ID # 6780499394, an oximeter cable was incorrectly coded and denied,



however, upon appeal the miscoding by the provider was discovered and the cable was manually approved, and the Participant received the cable;

8. If the correct code is used by the provider to bill for this equipment, barring any other error, it will be approved without prior authorization.


Maureen E. Ryan

Sworn to me this 6th day of Nov., 2014

Linda K. Hallion

Notary Public for South Carolina

My Commission Expires 6/3/15

Appellant's Response to Motion to
Dismiss

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

Case No. 2013-002415

Brook Waddle Appellant,

v.

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

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SC Court of Appeals

APPELLANT'S RESPONSE TO MOTION TO DISMISS.

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

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

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

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

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

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

Federal regulations require that Medicaid services be provided with "reasonable promptness." 42 U.S.C. 1396a(a)(8). In *Doe v. Kidd I*, the Fourth Circuit noted that courts have interpreted "reasonable promptness" to mean within 45 or 90 days:

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

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

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

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

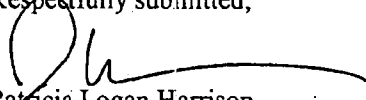
Appellant has also complained of the ongoing violations of 42 C.F.R. 431.244(a), which require DHHS hearing officers to base their decisions “exclusively” on evidence presented at a hearing. Obviously, if no hearing is provided, the hearing officer’s order dismissing a “fair hearing” appeal cannot be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

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

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

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

Respectfully submitted,


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

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

December 4, 2014

LIST OF EXHIBITS

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

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



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

November 19, 2013

CERTIFIED MAIL

Patricia Harrison, Esquire
611 Holly Street
Columbia SC 29205

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

Dear Ms. Harrison:

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

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

Sincerely,

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

EBH/ss
Enclosures (2)

Patricia Harrison Esquire

November 19, 2013

Page Two

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

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

JURISDICTION

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

BACKGROUND

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

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

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

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

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

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

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

The following documents were admitted as exhibits for the Petitioner:

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

6. Various DDSN Manual provisions;
7. A March 18, 2010, Discharge Summary from Greenville Hospital System;
8. The Service Coordinators' Record of Contact for the Petitioner dated for various times between 12/1/09 – 09/27/12;
9. DDSN HASCI Form 15 (9-10) dated 2/22/12 by Dr. Katherine Lumpkin;
10. ICD-9 Description of the E2510 Speech Generating Device;
11. Telephone Declaration of J. W. taken by Petitioner's attorney;
12. Telephone Declaration of B. W. taken by Petitioner's attorney;
13. Telephone Declaration of S. W. taken by Petitioner's attorney;
14. Affidavit of Don Kovach;
15. Declaration of Kathy Hoover, RN;
16. Attachments to Declaration of Kathy Hoover, RN;
17. Section 2 of the Home Health Services Manual, updated 10/01/12;
18. Section 2 of the Private Rehabilitation Therapy and Audiology Services Manual, update 10/01/12;
19. An August 20, 2010, News Release from the Comptroller General's Office about the budget challenges of FY 2010;
20. A May 8, 2009, cover letter enclosing documentation about the request for the speech generating device;
21. Affidavit of Lennie Mullis;
22. Packet of documents regarding the requested speech generating device;
23. Detailed Claims Report of Petitioner dated 10/16/2012;
24. Personal Care Needs Form, no date, for B.W.;

25. DDSN Annual Accountability Report, FY 2011-2012;
26. Document entitled Head and Spinal Cord Injury (HASCI) Waiver Recommendations for Revised Service Limits, Attachment D;
27. DDSN Service Coordination Manual, Revised July 1, 2011;
28. Documents from a Nursing Services Review of Petitioner by Vivian Koon; and
29. Photographs of Petitioner.

The following documents were admitted as exhibits for the Respondent:

1. Documents related to the original request for a speech generating device; and
2. The Current HASCI Waiver document.

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

ISSUES

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

1. The weekly hours of registered nursing that are needed by the Petitioner, taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.
2. The specific type of care and number of weekly hours of each type of care required by the Petitioner during the course of her treatment since her discharge from the hospital in May of 2007 consistent with the Medicaid Program, and the principle that the mother is not legally responsible for caring for the Petitioner.

3. The number of hours of the authorized care described in #2, above, that has been provided by the mother (according to her qualifications), and the cost of that care, which amount shall be paid to the mother.
4. In the future, the mother should be allowed to provide whatever care she is qualified to provide within the authorized hours of service set as described in #2, above, and shall be paid for such services at a rate to be determined upon remand.
5. The cost of an average digital speech device of the type described by Dr. Burton shall be determined and paid to the Petitioner to defray the cost of the more expensive device she purchased.

HISTORY OF SERVICE HOURS DISPUTE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DISCUSSION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Bowel program – implemented by the nurse – history of constipation

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

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

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

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

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

History of episodes of depression/anxiety

Tracheostomy in place – tracheoesophageal fistula

Dysphagia – GERD

Hypothyroidism

Staph coag negative bacteremia – treated with Rocephin”

Petitioner’s Exhibit 28 at 2.

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

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

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

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

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

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

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

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

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

I therefore find:

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

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

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

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

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

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

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

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

LEGAL DISCUSSION

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

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

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

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

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

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

I therefore find:

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

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

Hours for Which Petitioner's Mother Shall Be Compensated

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

CONCLUSIONS OF LAW

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

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

DISCUSSION

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

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

CONCLUSIONS OF LAW

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

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

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

DISCUSSION

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

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

DECISION

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

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

Any issues not addressed in this Order are deemed dismissed.

AND IT IS SO ORDERED.


Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina

November 19, 2013

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

December 23, 2013

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

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

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

Dear Ms. Harrison and Mr. Hepfer:

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

Sincerely,

Elizabeth B. Hutto

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

EBH/ss
Enclosures (2)



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

BACKGROUND

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

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

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

(Respondent's Motion for Reconsideration at 4)

DISCUSSION

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

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

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

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

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

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

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

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

ORDER

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

AND IT IS SO ORDERED.

Elizabeth B. Hutto

Elizabeth B. Hutto
Hearing Officer

DATED AT COLUMBIA,
South Carolina

December 23, 2013

Exhibit 3 B.W. v. DHHS, Response to DHHS' Motion filed May 1, 2014

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Brook Waddle,
Appellant/Respondent,

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

v.

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

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

I. Response to DHHS Request for Extension.

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

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

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

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

FILED
MAY 01 2014

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

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

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

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

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

S.C. Code Ann. § 1-23-630 provides that "Each administrative law judge of the [ALC] has the same power at chambers or in open hearing as do circuit court judges and to issue those remedial writs as are necessary to give effect to its jurisdiction." (2005) (emphasis added). This Court clearly has the authority to issue an order of contempt. *South Carolina Department of Labor v. Scruggs*, 102513 SCALC, 11-ALJ-11-0264-II, October 25, 2013. On August 1, 2013, this Administrative Law Judge issued a Rule to Show Cause, Order to Answer Petition for Injunctive Relief and Notice of Hearing for Injunctive Relief. That order required the

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

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

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

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

Respectfully submitted,



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

May 1, 2014

Exhibit 1

Emails

plh.cola@gmail.com

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

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

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

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

Trisha

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

Trisha:

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

Thanks,

Damon C. Wlodarczyk
Attorney and Counselor at Law
Riley Pope & Laney, LLC
2838 Devine Street
Post Office Box 11412 (29211)
Columbia, South Carolina 29205
Office: 803-799-9993
Facsimile: 803-239-1414
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5/1/2014

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

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

To: Rick Hepfer

Subject: W.

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

Thanks.

T.

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STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Brook Waddle,
Appellant/Respondent,

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

v.

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

PETITION/COMPLAINT FOR REMEDIAL WRIT

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

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

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

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

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

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

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

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

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

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

unclear what threshold or balancing test the ALC must apply in determining "good cause." *Id.* However, in *S.C. Dep't of Motor Vehicles v. Lajuenesse*, in a DMV context, the Administrative Law Judge suggested that good cause "may" require a balancing. 06-ALJ-21-0270-AP (March 4, 2008). Other ALC orders addressing injunctive relief under ALC Rule 16 or in the context of other stay issues have also utilized a balancing approach. In a DHEC matter analyzing the 2008 language, an ALJ concluded that the stay should be lifted after balancing the positions of the parties. *Hill v. S.C. Dep't of Health & 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 recognize that "Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* As Judge Hendricks noted, the United States Supreme Court has recognized that "Where such an experience can be avoided... it should be."

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

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

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

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

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

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

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

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

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

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

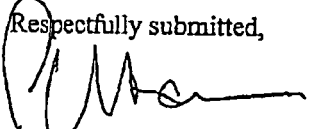
circuit court judges and to issue those remedial writs as are necessary to give effect to its jurisdiction." (2005) (emphasis added). This power is in addition to the power to hold DHHS in contempt and enforcement of Hearing Officer Hutto's order does not require a finding of willful contempt. (Although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


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June 20, 2014

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

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

VERIFICATION

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

Brook Waddle
Brook Waddle

Sandra Waddle
Sandra Waddle, Attorney in Fact

SWORN TO BEFORE ME THIS

20 day of June, 2014.

[Signature]
Notary Public for South Carolina

My Commission Expires

LIST OF EXHIBITS

1. November 19, 2013 Order of DHHS Hearing Officer Hutto
2. December 23, 2013 Order of DHHS Hearing Officer Hutto
3. May 1, 2014 Petition filed by Appellant in ALC
4. Affidavit of Sandra Waddle
5. Affidavit of Lennie Mullis
6. Peter B. v. Sanford, Report and Recommendation of Magistrate Judge
7. South Carolina Administrative Practice and Procedure Excerpt
8. *"To Stay or Not to Stay: Automatic Stays Before the Administrative Law Court in DHEC Matters,"* published in the September 2008 South Carolina Lawyer
9. November 2008 Letter from CMS to DHHS approving waiver costs
10. November 2009 Letter from CMS to DHHS approving waiver costs
.. ..

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June 23, 2014

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

Dear Attorney General Wilson:

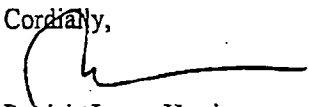
Enclosed is a Petition/Complaint which has been filed in the South Carolina Administrative Law Court in Brook Waddle v. DHHS. As in the *Linkhorn* case, DDSN (and DHHS) are refusing to provide the services which have been ordered. In Brook's case, we filed an administrative appeal in 2007. Her case has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

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

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

I can be reached at 803-360-5555.

Cordially,


Patricia Logan Harrison

c: Brook Waddle
Ken Anthony, Esq.

FILED

JUN 29 2014

SC ADMIN. LAW COURT

CERTIFIED SPECIALIST IN ESTATE PLANNING AND PROBATE LAW

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June 23, 2014

Hand Delivery

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

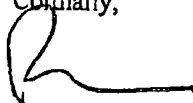
RE: Brook Waddle v. SCDHHS
Docket No. 13-ALJ-08-0603-AP

Dear Clerk:

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

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

Cordially,



Patricia L. Harrison

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

FILED

JUN 23 2014

SC ADMIN. LAW COURT

CERTIFIED SPECIALIST IN ESTATE PLANNING AND PROBATE LAW

0394

THE STATE OF SOUTH CAROLINA
Administrative Law Court

Brook Waddle,
Appellant/Respondent,

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

v.

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

SUMMONS

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

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

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

SOUTH CAROLINA ATTORNEY GENERAL

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

ATTORNEY FOR RESPONDENT



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

ATTORNEY FOR APPELLANT

Jun 20, 2014

FILED

JUN 23 2014

SC ADMIN. LAW COURT

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

COPY

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Brook Waddle,

Appellant/Respondent,

v.

South Carolina Department of Health and
Human Services,

Respondent/Appellant.

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

MOTION TO DISMISS
PETITION/COMPLAINT FOR
REMEDIAL WRIT

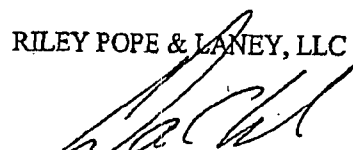
The Respondent/Appellant (hereinafter "SCDHHS") hereby moves as allowed by Rule 19 of the Rules of Procedure for the Administrative Law Court, for an Order dismissing the document captioned Petition/Complaint for Remedial Writ on the following grounds:

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

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

Signature Block Appears on Following Page

RILEY POPE & LANEY, LLC



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

Columbia, South Carolina
July 23, 2014

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, chief Administrative law judge

Appellate Case No. 2013-002415

Brook Waddle,

Appellant,

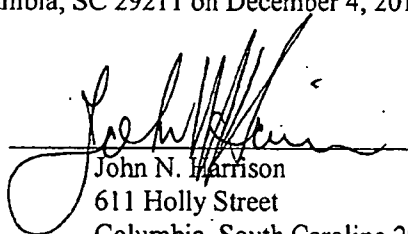
v

South Carolina Department of Health
and Human Services,

Respondent.

CERTIFICATE OF SERVICE

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



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

RECEIVED

DEC 09 2014

SC Court of Appeals

End of
Appellant's Response to Motion to
Dismiss

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

Case No. 2013-002415

Brook Waddle,
Appellant,

v.

South Carolina Department of Health and Human Services
Respondent.

RECEIVED

JUN 12 2015

SC Court of Appeals

BRIEF OF APPELLANT

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Attorneys for Appellant

The South Carolina Court of Appeals

Brook Waddle, Appellant,

v.

South Carolina Department of Health and Human
Services, Respondent.

Appellate Case No. 2013-002415

ORDER

Respondent has filed a motion to dismiss, asserting the underlying order is moot. Appellant has filed a return opposing the motion. After careful consideration, the motion is denied. Respondent shall serve and file its initial brief and designation of matter within thirty days.


FOR THE COURT

Columbia, South Carolina

cc: Patricia Logan Harrison, Esquire
Shealy Boland Reibold, Esquire
Kenneth C. Anthony, Jr., Esquire
Damon Christian Wlodarczyk, Esquire

FILED

January 16, 2015

RECEIVED

MAY 20 2015

THE STATE OF SOUTH CAROLINA

SC Court of Appeals

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

Case No. 2013-002415

Brook Waddle,
Appellant,

v.

South Carolina Department of Health and Human Services
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2. The hearing officer and the lower court exceeded their authority and violated Appellant's statutory rights contained at 42 U.S.C. 1396a(a)(3) and her constitutional right to due process guaranteed in the United States Constitution by refusing to provide an evidentiary hearing, instead basing her decision on evidence not introduced at an evidentiary hearing in violation of 42 C.F.R. 431.244(a).	
3. The hearing officer and the lower court violated 42 C.F.R. 431.240 by ignoring Appellant's request for an independent medical assessment of the need for the oximeter cable, which should have been provided at the expense of the State, because the hearing officer considered it necessary to have a medical assessment other than that of the individual who made the original determination.	
4. The hearing officer and the lower court exceeded their authority and violated Appellant's constitutional due process rights and the clear and unambiguous notice requirements of 42 C.F.R. 431.210 which require a written notice that (1) explain the agency's reason for	

denying payment for the oximeter cable and (2) identify the specific regulation or change in law that supported the agency's decision not to pay for the cable.

5. DHHS has violated the Americans with Disabilities Act by failing to provide the reasonable accommodations of paying for an oximeter cable that is needed to allow Appellant to remain in the least restrictive setting and Respondent failed to meet its burden under the ADA of proving that paying for the oximeter cable would fundamentally alter the State's system.

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2. The hearing officer and the lower court exceeded their authority and violated Appellant's statutory rights contained at 42 U.S.C. 1396a(a)(3) and her constitutional right to due process guaranteed in the United States Constitution by refusing to provide an evidentiary hearing, instead basing her decision on evidence not introduced at an evidentiary hearing in violation of 42 C.F.R. 431.244(a).
3. The hearing officer and the lower court violated 42 C.F.R. 431.240 by ignoring Appellant's request for an independent medical assessment of the need for the oximeter cable, which should have been provided at the expense of the State, because the hearing officer considered it necessary to have a medical assessment other than that of the individual who made the original determination.
4. The hearing officer and the lower court exceeded their authority and violated Appellant's constitutional due process rights and the clear and unambiguous notice requirements of 42 C.F.R. 431.210 which require a written notice that (1) explain the agency's reason for denying payment for the oximeter cable and (2) identify the specific regulation or change in law that supported the agency's decision not to pay for the cable.
5. DHHS has violated the Americans with Disabilities Act by failing to provide the reasonable accommodations of paying for an oximeter cable that is needed to allow Appellant to remain in the least restrictive setting and Respondent failed to meet its burden under the ADA of proving that paying for the oximeter cable would fundamentally alter the State's system.

II. Standard of Review.

This Court may reverse or modify the agency's decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are: (a) in violation of constitutional or statutory provisions; (b) in excess of the statutory authority of the agency; (c) made upon unlawful procedure; (d) affected by other error of law; (e) clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

"Statutory interpretation is a question of law." *Hopper v. Terry Hunt Constr.*, 373 S.C. 475, 479, 646 S.E.2d 162, 165 (Ct.App.2007). This court may decide matters of law with no particular deference to the lower court. *Pressley v. REA Constr. Co.*, 374 S.C. 283, 287-88, 648 S.E.2d 301, 303 (Ct.App.2007). Particularly, in a case raising a novel question of law regarding the interpretation of a statute, the appellate court is free to decide the question with no particular deference to the lower court. *I'On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 411, 526 S.E.2d 716, 719 (2000) (citing S.C. Const. art. V, §§ 5 and 9 ; S.C.Code Ann. §§ 14-3-320 and -330 (1976 & Supp.2005), and S.C. Code Ann § 14-8-200 (Supp.2005)); *Osprey, Inc. v. Cabana Ltd. Partnership*,

340 S.C. 367, 372, 532 S.E.2d 269, 272 (2000) (same); *Clark v. Cantrell*, 339 S.C. 369, 378; 529 S.E.2d 528, 533 (2000) (same). "The appellate court is free to decide the question based on its assessment of which interpretation and reasoning would best comport with the law and public policies of this state and the Court's sense of law, justice, and right." *Sloan v. South Carolina Bd. of Physical Therapy Examiners*, 370 S.C. 452, 636 S.E.2d 598 (S.C. 2006).

III. Statement of the Case.

The subject of this appeal is DHHS' January 9, 2013 denial of payment for an oximeter cable. R. 155, 159. In 2007, Appellant commenced an appeal alleging that DHHS failed to provide necessary medical services and equipment and those proceedings have been ongoing in the Executive Branch for more than seven years. The lengthy history of those proceedings is described in *Waddle v. DHHS*, DHHS Order dated November 19, 2013 at 1 to 3. A final state administrative order that is reviewable by the Judicial Branch has never been issued in that appeal that is now more than seven years old.¹

But, while Appellant's 2007 appeal was pending at DHHS and before the

¹ DHHS filed a motion to reconsider which was denied by the hearing officer in that 2007 appeal. *Waddle v. DHHS*, Order of Elizabeth Hutto dated December 23, 2013. That appeal is presently pending in the Administrative Law Court.

The hearing officer was not satisfied with this Response. R. 151. She "extended the due date" until April 2, requiring Appellant to provide documentation of the medical necessity for the oximeter cable. Id. But Appellant had asked the hearing officer to provide a medical assessment and a federal regulation required her to do so at government expense if she felt that such assessment was necessary. Then, instead of scheduling a hearing, on April 4, 2013, the DHHS hearing officer issued an order dismissing Brook's appeal. R. 147. The hearing officer dismissed Appellant's appeal without responding to her request for an independent medical assessment. R. 147-154.

Appellant filed a notice of appeal in Administrative Law Court and filed an initial brief. ALC Brief of Appellant. R. 58. Instead of filing a brief, as required by SCALC Rule 37, Respondent filed a Motion to Dismiss in the Administrative Law Court. R. 61. ALC Motion to Dismiss and ALC Order dated October 11, 2013 at 4. To the knowledge of counsel neither the Rules applicable to "Matters Heard on Appeal from Final Decisions of Certain Agencies" nor the Administrative Procedures Act authorize the Administrative Law Court to dismiss a case based on such a motion, except for ALC Rule 38 which applies only to a party failing to comply with the ALC's Rules. ALC Rules 33 to 41. But there is no allegation in this case that Appellant failed to

comply with any rule of the Administrative Law Court. That court, as an Executive Branch agency, is obligated to comply with its own rules requiring the State to file a brief in this case and to comply with federal law in the administration of the Medicaid program. 42 C.F.R. 431.223 prohibits the dismissal of a fair hearing appeal by any state entity without providing an evidentiary hearing where the appellant has an opportunity to present witnesses and to cross examine adverse witnesses, except where the recipient requests dismissal in writing or fails to appear at a scheduled hearing.

The Administrative Law Court improperly dismissed Appellant's appeal without requiring DHHS to file a brief meeting the requirements of ALC Rule 37. R. 2. The ALC order dismissing Appellant's appeal was received by Appellant's counsel on October 15, 2013. Appellant filed this appeal in the South Carolina Court of Appeals on November 12, 2013. R. 60.

IV. Statement of the Law

Medicaid is a "cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). The federal and state

governments share the cost of Medicaid, but each state government administers its own Medicaid plan. *See Conn. Dep't of Soc. Servs. v. Leavitt*, 428 F.3d 138, 141 (2d Cir.2005). State Medicaid plans must, however, comply with applicable federal law and regulations. *Doe v. Kidd I*, 501 F.3d 348, 351 (4th Cir. 2007) citing *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). ("Once a state elects to participate in the program, it must comply with all federal Medicaid laws and regulations." *Id.*) *See also* 42 U.S.C. § 1396c; 42 C.F.R. § 430. Any state that elects to participate in the Medicaid program must designate "a single State Agency" to administer— or to supervise the administration of— the state's Medicaid plan. *See* 42 U.S.C. § 1396a(a)(5). In South Carolina, the South Carolina Department of Health and Human Services (DHHS) is the Single State Agency responsible for the administration of the program. *Doe v. Kidd I* at 351. Although the State agency may delegate to other entities the performance of certain responsibilities, *see* 42 C.F.R. § 431.10(e), the State agency must (1) "[h]ave methods to keep itself currently informed of the adherence of local [entities] to the State plan provisions and the agency's procedures for determining eligibility," and (2) "[t]ake corrective action to ensure their adherence," 42 C.F.R. § 435.903.

The Medicaid Act requires that states electing to participate in the Medicaid program must grant "an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3).

The Code of Federal Regulations requires explicit information to be contained in notices provided pursuant to 42 U.S.C. 1396a(a)(3). The notice must be in writing and it must contain (1) the reasons for the intended action; and (2) the specific regulations that support, or the change in federal or state law that requires the action. 42 C.F.R. 431.210(b) and (c). Where such notice is not provided at least 10 days before the adverse action, services must not be reduced or terminated pending the fair hearing decision. 42 C.F.R. 431.211 and 431.230. Services must be reinstated where advance notice meeting these requirements is not provided. 42 C.F.R. 431.231

A hearing on the merits must be provided to any applicant who requests it because she believes the agency has taken an action erroneously or where a claim is denied or not acted upon with reasonable promptness. 42 C.F.R. 431.220. States are prohibited from dismissing a fair hearing appeal without providing an evidentiary hearing except in two extremely limited circumstances.

42 C.F.R. 431.223. One is where the recipient withdraws the request in writing, and, two, where the participant fails to appear at a scheduled hearing without good cause. *Id.*

CMS regulations require the hearing officer to base decisions "exclusively on evidence introduced at the hearing." (Emphasis added.) 42 C.F.R. 431.244(a). The decision must identify the regulations supporting the decision, the reasons for the decision and the supporting evidence (which must have been introduced at the hearing). 42 C.F.R. 431.244(d) and (e). The Medicaid recipient must be allowed to bring witnesses to the evidentiary hearing, to present argument without undue interference and to question or refute testimony or evidence. 42 C.F.R. 431.242. The recipient must be given an opportunity to confront and cross-examine adverse witnesses, which simply cannot occur when a hearing is not provided. 42 C.F.R. 431.242(e).

42 C.F.R. 431.244(f) requires that the State agency "must take final administrative action ... [ordinarily, within 90 days] of the date a fair hearing is requested. *See* 42 C.F.R. § 431.244(f)(1)(ii) ("regulation"). In *Shakhnes v. Berlin*, the Second Circuit held that:

...the regulation's 90-day requirement 'merely further defines or fleshes out the content' of the right to 'an opportunity' for Medicaid fair

hearings, such that Plaintiffs have a right— enforceable under § 1983— to final administrative action "[ordinarily, within 90 days" of their request, *see* 42 C.F.R. § 431.244(f).

689 F.3d 244, 254 (2d Cir. 2012). That court held that:

We further conclude that the right to an opportunity for Medicaid " fair hearings" includes a right to a decision following such hearings. 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." *See Harris*, 127 F.3d at 1009.

Id. at 256.

In addition to the specific requirements contained in 42 C.F.R. 431.200 et. seq., the state's Medicaid fair hearing system must be in compliance with all of the due process requirements the United States Supreme Court set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970). As the Second Circuit discussed in *Shakhnes*:

...*Goldberg* says that "the decisionmaker's conclusion ... must rest solely on the legal rules and evidence adduced at the hearing," and that " the decision maker should state the reasons for his determination and indicate the evidence he relied on. " *Goldberg*, 397 U.S. at 271, 90 S.Ct. 1011 (emphasis added). In addition, the *Goldberg* Court emphasized that " an impartial decision maker is essential." *Id.* We see little reason why this would be so unless the right to a fair hearing includes the right to a decision.

Supra at 256.

In addition to meeting all of the requirements of the Medicaid Act, DHHS is required by the Americans with Disabilities Act (ADA) and *Olmstead*, as well

as state law, to provide services in the least restrictive environment. *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007), citing *Olmstead v. L.C.* 527 U.S. 581 (1999); S.C.Code Ann. § 44-20-20 (2006). The United States Supreme Court has determined that the burden of proving whether an action would cause a fundamental alteration under the ADA lies with the State. *Olmstead* at 603. Once a qualified individual proves his *prima facie* case in an action brought under the ADA, i.e. demonstrates that (1) he is a qualified person with disabilities, as defined in the ADA, (2) the State has determined that community based treatment is appropriate and (3) he does not oppose living in the community, then the burden shifts to the State to prove that providing the requested service or equipment would require a "fundamental alteration" in the nature of its programs. *Olmstead*, 527 U.S. at 604.

V. **Argument**

1. **The hearing officer and the lower court exceeded their authority and erred as a matter of law by dismissing Appellant's request for a fair hearing in violation of 42 C.F.R. 431.223, because Appellant did not request dismissal in writing and she did not fail to appear at a scheduled hearing.**

Federal regulations clearly and unambiguously specify very limited circumstances in which a State may dismiss a Medicaid recipient's fair hearing appeal. The applicable regulation contained at 42 C.F.R. 431.223, titled "Denial

or dismissal of request for a hearing" provides that:

The agency may deny or dismiss a request for a hearing if-

- (a) The applicant or beneficiary withdraws the request in writing; or
- (b) The applicant or beneficiary fails to appear at a scheduled hearing without good cause.

The hearing officer's order fails to mention or rely upon this, or any other federal statute or regulation. Likewise, the Administrative Law Court failed to address 42 C.F.R. 431.223, which applies to it as an Executive Branch agency of the State. Instead, the hearing officer relied upon a state regulation, DHHS Regulation 126-154 and the Administrative Law Court improperly upheld that decision. DHHS Regulation 126-154 provides that:

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

The hearing officer exceeded her statutory authority by relying upon a state regulation which contradicts not only the clear and unambiguous regulation of CMS, the federal agency authorized by Congress to administer the Medicaid program, but it also conflicts with the agency's own regulation which states:

§ 126-399. Conflict Between State and Federal Regulations

When the requirements of the State and the Federal regulations are not in agreement, the requirements of the Federal regulations shall prevail.

In 42 U.S.C. 1396a(a)(3), Congress clearly and unambiguously mandated that DHHS must:

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

Federal regulations contained at 42 C.F.R. 431.223 authorize the State to deny or dismiss a hearing under limited circumstances, none of which that are not present in this case:

§ 431.223. Denial or dismissal of request for a hearing

The agency may deny or dismiss a request for a hearing if-

- (a) The applicant or beneficiary withdraws the request in writing; or
- (b) The applicant or beneficiary fails to appear at a scheduled hearing without good cause.

This requirement is not complicated or hard to understand. It is not rocket science. The State must simply provide the recipient an evidentiary hearing meeting the requirements clearly set forth in 42 C.F.R. 200 et seq., then make a decision based on the evidence presented at the hearing. Likewise, 42 C.F.R. 431.244(a) could not be more clear in requiring that "Hearing recommendations

or decisions must be based exclusively on evidence introduced at the hearing.”

When a Medicaid participant has not been provided an evidentiary hearing, it is impossible to meet the federal requirement that the decision must be based entirely on evidence introduced at the hearing. Appellant did not request, in writing or otherwise, that her appeal be dismissed and she never failed to appear at a scheduled hearing - the hearing officer refused to even schedule a hearing.

Appellant's rights have been prejudiced by Respondent's violations of federal law, the hearing officer and the Administrative Law Judge exceeded the statutory authority of the Executive Branch and the decision to dismiss Appellant's appeal was made upon unlawful procedure. The act of dismissing Appellant's "fair hearing" was arbitrary and capricious and these Executive agencies denied Appellant's constitutional right to due process, as will be discussed in more detail below. Appellant requests that this honorable Court reverse the decision of these Executive Branch agencies and that they be required to comply with federal law in the administration of the Medicaid program.

Appellant requests an order prohibiting Respondent from terminating services prior to providing an evidentiary hearing, paying for the oximeter cable and finding that she is the prevailing party in this appeal. Appellant requests a

finding that the State acted without substantial justification and that the court award legal fees pursuant to S.C. Code of Laws 15-77-300. Such an award is appropriate and just in this case because Appellant contested state action where the agency acted without substantial justification in pressing its claim to deny critical medical equipment by dismissing Appellant's request for a fair hearing and there are no special circumstances that would make the award of attorney's fees unjust. Since the DHHS hearing officer and the Administrative Law Judge willingly and knowingly refused to provide an evidentiary hearing and, in any event, it is unclear whether either Executive tribunal has the authority to award or deny fees under S.C. Code of Laws 15-77-300, Appellant requests that this Court set forth in its order the correct procedure in Medicaid appeals for awarding fees pursuant to that statute.²

2. **The hearing officer and the lower court exceeded their authority and violated Appellant's statutory rights contained at 42 U.S.C. 1396a(a)(3) and her constitutional right to due process guaranteed in the United States Constitution by refusing to provide an evidentiary hearing, instead basing their decisions on evidence not introduced at an evidentiary hearing in clear violation of 42 C.F.R. 431.244(a).**

Elizabeth Hutto, who is now the Deputy Director of DHHS, in charge of

² S.C. Code § 15-77-310 provides that "The party shall petition for the attorney's fees within thirty days following final disposition of the case. The petition must be supported by an affidavit setting forth the basis for the request." But it does not specify what "court" has the authority to award fees in an action brought for violation of the Medicaid Act.

Eligibility, Enrollment and Member Services, was the hearing officer who heard Appellant's appeal in October of 2012 and issued orders on November 19, 2013 and December 23, 2013. *Waddle v. DHHS, supra*. Ms. Hutto described in her November 19, 2013 order the due process rights of Medicaid participants as follows:

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)...Federal regulations require that the notice of adverse action must 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.

Waddle v. DHHS, DHHS Order dated November 19, 2013 at 25: That order describes the procedure that DHHS must follow to continue benefits during an appeal. *Id.* at 26. She found that DHHS "violated Petitioner's due process rights in enforcing its waiver reductions against her during the pending appeal." *Id.* at 30.

As discussed above in this brief, 42 C.F.R. 431.244(a) required the hearing officer and the Administrative Law Court to base their decisions exclusively on evidence introduced at the hearing. Those decisions simply could not possibly have been based exclusively on evidence presented at a hearing - without providing a hearing. Appellant's constitutional rights to due process

were egregiously denied by the agency and the Administrative Law Court. The agency and the Administrative Law Court violated the Supremacy Clause and the Fourteenth Amendment of the United States Constitution by refusing to provide an opportunity for Appellant to be heard on her claim.

The United States Court of Appeals for the Fourth Circuit has addressed the issue of the requirements for notice and a hearing under the Medicaid Act, and that Court's opinion is binding on DHHS and the Administrative Law Court in Medicaid appeals. In *K.C., by and through Africa H. v. Shipman*, the district court granted a preliminary injunction to severely disabled plaintiffs on their claims that the North Carolina State Medicaid Agency violated their rights under the Medicaid Act and the Due Process Clause of the Fourteenth Amendment when the State reduced their health care services without providing notices meeting the requirements of 42 C.F.R. 431.210 and an opportunity for a hearing. Case No. 12-1575 (4th Cir. May 10, 2013). The district court ruled in that case that plaintiffs were entitled to the notice and appeal rights provided for by the Medicaid statute and the Fourteenth Amendment and that the defendants had failed to comply with those requirements. *Id.* at 111. (In district court, the case was captioned *L.S. v. Delia*, 5:11-CV-354-FL (NCED March 29, 2012)) The United States Court of Appeals for the Fourth Circuit denied the State's

appeal of the district court's decision, upholding the findings of the district court judge. Case No. 12-1575 (4th Cir. May 10, 2013).

The district court in that case recognized that: "The Medicaid Act requires participating states and managed care entities to provide each Medicaid recipient with adequate written notice and an opportunity for an impartial hearing before services are denied, reduced or terminated. §§ 1396a(a)(3) and 1396u-2(a); 42 C.F.R. §§ 431.200 and 438" and that federal approval of the State's Medicaid Plan "specifies that defendant Delia must provide the opportunity for a fair hearing pursuant to federal regulations, 42 C.F.R. § 431.200 subpart E, to every waiver participant whose services are denied, suspended, reduced, or terminated. 42 C.F.R. § 431.200(a)." In ruling that the defendants violated the Medicaid participants' rights under federal law and due process, the North Carolina federal district court held that:

... plaintiffs were entitled to the notice and appeal rights outlined in the Medicaid regulations, cited above, as well as under general principles of due process. See *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 786-87 (1980); *Goldberg v. Kelly*, 397 U.S. 254, 269-71 (1970); *McCartney ex rel. McCartney v. Cansler*, 608 F.Supp.2d 694, 699 (E.D. N.C. 2009).

Id. The district court in North Carolina also ruled that:

... plaintiffs are likely to succeed on the merits on their claims that the same actions violated plaintiffs' due process rights under the Fourteenth

Amendment. Plaintiffs have set forth the applicable law in detail, including the Supreme Court decision in *Goldberg*, which required that welfare recipients have timely and adequate notice detailing the reasons for proposed termination, that the opportunity to be heard be tailored to the capacities and circumstances of those to be heard, an opportunity to confront and cross-examine the witnesses relied on by the opposing side, and an impartial decision maker. 397 U.S. at 268-71.

Id. Further, the district court recognized that: "Additionally, the public interest always lies with upholding the law and having the mandates of the Medicare Act and due process enforced." Appellant's case also presents a matter of great public concern and these violations are bound to continue unchecked unless this Court upholds the due process rights of severely disabled Medicaid waiver participants who do not have access to the arsenals available to the State.

In the present case, it is undisputed that the hearing officer and the Administrative Law Court refused to grant Appellant's request for a fair hearing. The requirement to provide an evidentiary hearing is clear and unambiguous and there is no doubt but that the agency and the Administrative Law Court knowingly ignored Appellant's constitutional rights to due process by failing to provide the requisite hearing. This is not an isolated case.

These same actors violated the right of Peter Brown to an evidentiary hearing through similar diversionary tactics and this Court ordered DHHS to provide Peter with a hearing on the merits of his case in 2011. *Peter Brown v.*

DHHS, 393 S.C. 11, 709 S.E.2d 701, 705. (S.C.App. 2011). But, two years later, DHHS again dismissed Peter's appeal over his objections without providing an evidentiary hearing and his appeal is pending in this court and in an action filed in the federal district court. *Peter B. v. Sanford*, Case No. 6:10-767 (DCSC March 7, 2013).

The agency should be enjoined from reducing Appellant's services (including durable medical equipment) without providing an evidentiary hearing required by 42 U.S.C. 1396a(a)(3), now and in the future, as these violations are subject to repetition, yet these Executive Branch agencies have evaded review by the Judicial Branch.

For the reasons set forth above, Appellant prays for an order enjoining DHHS from reducing or terminating services (including durable medical equipment) prior to providing proper notice and an evidentiary hearing on the merits and finding that she is the prevailing party in this appeal. Appellant prays for an order finding that the State acted without substantial justification and for an award of legal fees.

3. The hearing officer and the lower court violated 42 C.F.R. 431.240 by ignoring Appellant's request for an independent medical assessment of the need for the oximeter cable, which should have been provided at the expense of the State, because the hearing officer considered it necessary to have a medical assessment other than that of the

individual who made the original determination.

On March 27, 2013, ignoring Appellant's March 19, 2013 written request for an independent medical assessment, the hearing officer improperly placed the obligation to provide "documentation of the medical necessity of the cable" on Appellant. The hearing officer shifted to the Appellant, who cannot lift her arms or move her legs and cannot even speak, the burden of obtaining, at the recipient's expense, an independent medical assessment in violation of 42 C.F.R. 431.240(b). That clearly violated that federal regulation, which requires that:

If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and *if the hearing officer considers it necessary to have a medical assessment* other than that of the individual involved in making the original decision, such a medical assessment must be obtained at agency expense and made part of the record. (Emphasis added.)

This federal regulation is not difficult to understand and it places the burden on the State to obtain and pay for an independent medical assessment where, as in this case, (1) the hearing involves medical issues such as those concerning a diagnosis or a review team's decision, and (2) the hearing officer considers another medical assessment to be necessary. With those conditions met, the federal regulations provide that the assessment must be obtained at agency expense and must be made part of the record. Instead, the hearing officer

dismissed Appellant's appeal in violation of a multitude of federal regulations and Appellant's due process rights. The hearing officer erred as a matter of law and exceeded her authority by placing this burden on Appellant, a severely disabled quadriplegic Medicaid participant who struggles each and every day just to stay alive and breathing after DHHS illegally and repeatedly reduced her services while her 2007 appeal has been pending for seven years. In her November 19, 2013 order, now Deputy Hutto (who was then a hearing officer) described Appellant as follows:

The medical records review conducted by the Respondent and the testimony of witnesses for both parties indicate that the Petitioner is 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

Waddle v. DHHS, Order dated November 19, 2013 at 24.

42 C.F.R. 431.240 means something. This requirement was not included in the federal regulations for no reason at all. It was included in those regulations by the federal agency authorized by Congress to administer the federal Medicaid program after publication in the federal register and opportunity for public comment. That federal regulation says that the hearing officer "must" obtain an independent medical assessment, it does not say "may."

CMS understood that impoverished Medicaid recipients do not have money to pay for expert opinions and that federal agency instructed the States that when a hearing officer determines that a medical assessment is necessary, the hearing officer must obtain the assessment at State expense. This responsibility cannot be met by a hearing officer sending an email saying that she did not like Appellant's Response to the hearing officer's (illegal) interlocutory order.

The intentional violation of this requirement is a matter of great public concern. Medicaid waiver participants are the most disabled and vulnerable citizens of our state and they must, by definition, be impoverished in order to qualify for Medicaid benefits. This violation is subject to repetition, yet it has evaded review again and again, where Appellant's services have been reduced without medical justification. Appellant requests an order requiring DHHS to obtain an independent medical assessment at government expense when requested by a recipient prior to terminating or reducing services in this and all future Medicaid appeals in which the hearing officer determines that an additional medical assessment is needed.

Appellant prays for an order finding that she is the prevailing party on this issue, that the State acted without substantial justification and for legal fees.

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4. The hearing officer and the lower court exceeded their authority and violated Appellant's constitutional due process rights and the clear and unambiguous notice requirements of 42 C.F.R. 431.210 which require a written notice that (1) explain the agency's reason for denying payment for the oximeter cable and (2) identify the specific regulation or change in law that supported the agency's decision not to pay for the cable.

Respondent's notice was defective in this case and this violation of 42 C.F.R. 431.210 is subject to repetition, yet this violation also evaded review again and again with this same Appellant. Deputy Hutto of DHHS (who was then a hearing officer) found in her Order issued on November 19, 2013 the following violations:

Referring to the notice dated March 14, 2007, Ms. Hutto found that "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. Order at 7.

As to the notice dated March 29, 2007, Ms. Hutto stated: "Again, no statute or regulations were cited on this notice not was there any justification or analysis regarding whether the cost for this care would be greater than the cost of a nursing home...This notice made no mention of continued benefits pending appeal."

According to that order, the denial notices sent to Appellant upon discharge from the hospital in 2007 "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. Order at 22. The reasons for the denials were "erroneous" according to the uncontradicted testimony of the DHHS witness. Id. While Appellant's appeal was pending, Appellant's "services were improperly reduced several times" and these reductions "occurred without notice and the

opportunity to appeal." Id.

According to the hearing officer, in July, 2008, when DHHS reduced Appellant's benefits while her 2007 appeal was pending: "There is no notice in the record regarding this service reduction." Order at 9 and 22.

Appellant's services were again reduced "improperly" in July, 2009, while her 2007 appeal was pending. Id. at 11. Hearing Officer Hutto stated in her November 19, 2013 order that: "There is no notice in the record regarding this reduction." Order at 9 and 10. The hearing officer found that "The Respondent again failed to provide proper notice." Id. at 22.

Waddle v. DHHS, supra.

Appellant requests an order finding that Respondent's notice was defective, these violations have been longstanding and that DHHS should be enjoined from terminating or reducing services without providing written notices meeting all of the requirements of 42 C.F.R. 431.210. Appellant requests that this Court rule that Appellant is the prevailing party on this issue, that the state Executive Branch tribunals and DHHS were not substantially justified in failing to provide proper notice and that Appellant's legal fees be paid pursuant to S.C. Code of Laws 15-77-300.

5. **DHHS has violated the Americans with Disabilities Act by failing to provide the reasonable accommodations of paying for an oximeter cable that is needed to allow Appellant to remain in the least restrictive setting and Respondent failed to meet its burden under the ADA of proving that paying for the oximeter cable would fundamentally alter the State's system.**

Respondent is required by the ADA and *Olmstead*, as well as state law, to provide services in the least restrictive environment. *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007), citing *Olmstead v. L.C.* 527 U.S. 581 (1999); S.C.Code Ann. § 44-20-20 (2006). The United States Supreme Court has determined that the burden is on the State to prove that a requested accommodation would cause a fundamental alteration under the ADA once the disabled person has met her *prima facie* case by demonstrating that (1) she is a qualified person with disabilities, as defined in the ADA, (2) the State has determined that community based treatment is appropriate and (3) she does not oppose living in the community. At that point, the burden then shifts to the State to prove that providing the accommodation would require a "fundamental alteration" in the nature of its programs. *Olmstead*, 527 U.S. at 603 and 604. The State has not met its burden.

There can be no question that Appellant has clearly presented a *prima facie* case demonstrating that she is a disabled person, that the State has determined that her receiving services in the community is appropriate and that she does not oppose receiving services in the community - indeed that is her clear choice. The State has totally failed to meet its burden of proving that providing Appellant with an oximeter cable would fundamentally alter the

State's programs and that providing this equipment would be inequitable "given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons" who are disabled.

In discussing the meaning of "fundamental alteration," the plurality in *Olmstead* instructed the States that:

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.

Id. at 604. One way that the State may meet its burden by demonstrating that it has made reasonable modifications to its programs is to demonstrate that it has a comprehensive or effectively working plan to provide services in less restrictive settings:

If, for example, the State were to demonstrate that it had *a comprehensive, effectively working plan* for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.

Id. at 605-606 (emphasis added). But, unlike most states, South Carolina does not have a comprehensive or effectively working *Olmstead* plan.

Not only has the State failed to prove that providing the oximeter cable would cause a fundamental alteration in its programs, it is obvious from the protracted litigation in this case in which the State has denied Appellant's simple request for a fair hearing that State taxpayers have spent far more money defending an indefensible position than they would have spent paying for the needed device. As Judge Baxley found in *T.R. v. South Carolina Department of*

Corrections:

We are now eight years into this litigation.³ 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.

T.R. v. South Carolina Department of Corrections, Case No. 2005-CP-2925 at 45, Richland County Court of Common Pleas, January 8, 2014.

The same obstructionist tactics exhibited by the State's attorneys in *T.R.* have been used by Executive Branch state agencies in Appellant's case to keep her from receiving a simple device that she needs to measure her oxygen supply.

³ Appellant's appeal entering into its eighth year, having been filed in 2007.

In *People v. Murray*, the conviction of Michael Jackson's personal physician for manslaughter was recently upheld by the California Court of Appeals, in part because the jury found that he failed to use an oximeter to properly monitor Mr. Jackson's vital signs. Case No. B237677 (Cal.Ct.Ap. January 15, 2014). That court reported that: "According to expert medical testimony presented at trial using a proper pulse oximeter could have saved Mr. Jackson's life." Id. at fn 8.

It is not inconsequential that as a condition of receiving 70% matching federal funding to operate the Medicaid program in South Carolina, DHHS has assured the federal government that it will provide necessary safeguards to protect the health and welfare of Medicaid waiver participants like Appellant. 42 C.F.R. 441.464. The failure to provide this device and the patterns and practices complained of in Appellant's 2013 complaint (R. 152, 159) has squarely placed her at risk of institutionalization. *Peter B. v. Sanford*, Case No. 6:10-cv-00767, Report and Recommendation, November 24, 2011.

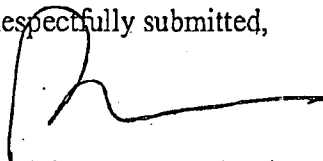
Appellant requests an order finding that Respondent is in violation of the Americans with Disabilities Act by failing to prove that providing the requested cable is not a reasonable accommodation and that it would fundamentally alter the State's programs for DHHS to provide the cable, that Appellant is the prevailing party on this issue, that Respondent was not substantially justified in

denying payment for this device and that she is entitled to an award of legal fees pursuant to S.C. Code 15-77-300.

VI. Conclusions

However complicated and convoluted other provisions of the Medicaid Act may be, federal law is quite clear and unambiguous that an evidentiary hearing must be granted to any participant who requests one. Appellant has shown that her statutory and constitutional rights to due process have been violated. In addition to demonstrating other violations of the Medicaid Act described herein, Respondent has failed to prove that paying for the oximeter cable would fundamentally alter the State's programs and Appellant is entitled to an order finding that Respondent has violated the Americans with Disabilities Act. Appellant requests an order granting the relief requested in her Brief. Appellant prays for an order finding that she is the prevailing party, that the State was not substantially justified in failing to provide the oximeter cable and that she is entitled to legal fees pursuant to S.C. Code 15-77-300, along with instructions for claiming those fees.

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM SOUTH CAROLINA
Administrative Law Court

Ralph King Anderson III, Administrative Law Judge
Trial Court Case No.: 2013-ALJ-080267-AP

Appellate Case No.: 2013-002415

Brook Waddle,.....Appellant,

v.

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

RESPONDENT'S FINAL BRIEF

**SOUTH CAROLINA DEPARTMENT
OF HEALTH AND HUMAN SERVICES**

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STATEMENT OF ISSUES ON APPEAL

- I. THE APPEAL SHOULD BE DISMISSED AS MOOT
- II. THERE WAS NO ERR IN DISMISSING WADDLE'S APPEAL FOR FAILING TO COMPLY WITH THE HEARING OFFICER'S ORDER (WADDLE'S ISSUES 1 & 2)
 - A. Waddle failed to appeal the hearing officer's procedural dismissal and, therefore, the dismissal is the law of the case and the present appeal should be dismissed.
 - B. There is substantial evidence in the Record on Appeal, which supports the hearing officer's order to dismiss Waddle's appeal.
- III. WADDLE'S REMAINING ARGUMENTS ARE NOT PRESERVED FOR REVIEW (WADDLE'S ISSUES 3, 4 AND 5)

STATEMENT OF THE CASE

This matter is before the Court of Appeals from an Order of the South Carolina Administrative Court ("ALC") affirming an Order of Dismissal issued by the Respondent, the South Carolina Department of Health and Human Services ("DHHS"), regarding the denial of Appellant's ("Waddle") request for durable medical equipment ("DME"), specifically an oximeter cable.

Waddle was injured in an automobile accident in 2005, which rendered her quadriplegic. Following the accident, Waddle became a Medicaid-eligible individual, who has been receiving services under the South Carolina Head and Spinal Cord Injury ("HASCI") waiver program. Under the waiver program, participants can receive a mix of services through the South Carolina Department of Disabilities and Special Needs ("DDSN"). Waivers are mechanisms within the Medicaid program under which, by having certain generic requirements of the Medicaid program "waived," States are able to provide services to eligible participants in ways not allowed under the regular Medicaid program. This waiver and other waiver programs operated by DDSN are for home and community based services under Section 1915(c) of the Social Security Act. 42 U.S.C. § 1396n(c). These types of waivers allow services to be provided in the home or community in lieu of institutional services. DDSN is responsible for the day-to-day operations of the waiver program, but DHHS is the single agency responsible for the South Carolina Medicaid program. [R. pp. 2-3].

Apria Healthcare, Inc. ("Apria"), is a provider of DME. Apria submitted to KePro, an agent of DHHS, a prior authorization request on behalf of Waddle for a piece of DME, specifically requesting an oximeter cable, which measures the oxygen saturation of the blood. However, the request was denied because Apria did not provide

any supporting clinical information with the request. Both Waddle and DHHS attempted to resolve the issue without success. [R. p. 3].

On January 31, 2013, Waddle filed an appeal of the denial of the oximeter cable to DHHS's Division of Appeals and Hearings. On February 5, 2013, the DHHS hearing officer issued a Prehearing Conference Order requiring DHHS "to submit [by March 19, 2013] a summary of issues discussed, whether consensus was reached and any remaining issues." The Order also instructed Waddle "to submit a statement of intention to continue the appeal process and attend a Fair Hearing." Id.

Both DHHS and Waddle responded to the Prehearing Order on March 19, 2013. However, Waddle erroneously e-mailed her response to a number of individuals, none of whom were the assigned hearing officer. The e-mail was ultimately forwarded to the hearing officer who responded to Waddle on March 27, 2013 by informing her that the response did not "address the issue of my case (denial of prior authorization of an oximeter cable for [Waddle])" and that Waddle needed to "include with [her] response the documentation of medical necessity for the cable." The hearing officer gave Waddle until April 2, 2013 to respond. Waddle did not respond. Id.

On April 4, 2013, the agency hearing officer issued an Order dismissing Waddle's appeal on procedural grounds. Specifically, that Waddle abandoned her appeal by failing to notify the hearing officer by the due date of her intention to continue the appeal process and attend a fair hearing. [R. p. 4].

Waddle appealed the Order dismissing the appeal to the Administrative Law Court ("ALC"), which affirmed the dismissal in an Order dated October 11, 2013, which is the subject of this appeal.

STATEMENT OF FACTS

The ALC's Order concisely sets forth the relevant facts. [R. pp. 2-4, 5-6]. Additionally, facts as relevant to the issues on appeal are more fully set forth below as needed.

STANDARD OF REVIEW

The standard of review is governed by the Administrative Procedures Act. S.C. Code Ann. § 1-23-380 provides in part that appellate review must be confined to the record and the appellate court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The Court may affirm the agency's decision or remand the matter for further proceeding.

The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

- (a) in violation of constitutional or statutory provisions;
- (b) in excess of the statutory authority granted of the agency;
- (c) made upon unlawful procedure;
- (d) affected by other error of law;
- (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
- (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-380(4)&(5); Doe v. S. Carolina Dep't of Health & Human Servs., 398 S.C. 62, 70-71, 727 S.E.2d 605, 609-10 (2011).

ARGUMENTS

I. THE APPEAL SHOULD BE DISMISSED AS MOOT

Generally an appellate court “will not pass on moot and academic questions or make an adjudication where there remains no actual controversy.” Sloan v. Dep’t of Transp., 379 S.C. 160, 167, 666 S.E.2d 236, 240 (2008) (internal citations omitted).

In the present case, the healthcare provider, Apria, incorrectly coded the request for the oximeter cable and, therefore, the request was denied. However, the coding issue was discovered when the denial was appealed and the cable was approved manually and Waddle received the cable and continues to receive the cable. Moreover, if the correct code is used by the provider in the future, barring any other error, it will be approved without prior authorization. [R. pp. 65-66].

Based upon the fact that the coding error was identified and the DME provided to Waddle, the issue on appeal is moot. Even if Waddle prevails in her appeal to this Court, the relief would be to remand the matter to DHHS’s Division of Appeals and Hearings for a fair hearing to determine whether or not the denial of the oximeter cable was proper, and whether or not the DME should be provided to Waddle. As DHHS has resolved the issue and provided the oximeter cable to Waddle, and DHHS has indicated that absent any future coding error the oximeter cable will continue to be provided without prior authorization, there is no need for a fair hearing or relief that the fair hearing officer could provide. As such, the present appeal should be dismissed as moot as there remains no actual controversy.

II. THERE WAS NO ERR IN DISMISSING WADDLE’S APPEAL FOR FAILING TO COMPLY WITH THE HEARING OFFICER’S ORDER (WADDLE’S ISSUES 1 & 2)

- A. Waddle failed to appeal the hearing officer’s procedural dismissal and, therefore, the dismissal is the law of the case and the present appeal should be dismissed.

Waddle set forth five (5) issues on appeal to the ALC in her Initial Brief. [R. p. 75]. In reviewing the arguments presented to the ALC, none assign any err as to the hearing officer's Order dismissing the appeal for failing to provide the information requested in the Prehearing Conference Order. [R. pp. 89-102]. Waddle first addressed the procedural dismissal in her Amended Reply Brief. [R. pp. 135-137].

It is well-settled that an un-appealed ruling is the law of the case. Judy v. Martin, 381 S.C. 455, 458, 674 S.E.2d 151, 153 (2009). Moreover, "an argument made in a reply brief cannot present an issue to the appellate court if it was not addressed in the initial brief. Glasscock, Inc. v. U.S. Fid. & Guar. Co., 348 S.C. 76, 81, 557 S.E.2d 689, 692 (Ct. App. 2001) citing Jackson v. Bi-Lo Stores, Inc., 313 S.C. 272, 277, 437 S.E.2d 168, 171 (Ct.App.1993).

Since Waddle first argued in her Reply Brief to the ALC that the hearing officer erred in procedurally dismissing her appeal without a fair hearing allegedly in violation of 42 C.F.R. 431.223, the argument was not properly preserved for appellate review and the issue presently before the Court should be dismissed.

- B. There is substantial evidence in the Record on Appeal, which supports the hearing officer's order to dismiss Waddle's appeal.

There is substantial evidence in the record to support the hearing officer's Order dismissing Waddle's appeal for her failure to provide information requested in the Prehearing Conference Order. At issue in this case are the following regulations:

42 C.F.R. §431.205 provides in part that the Medicaid agency (DHHS) is responsible for maintaining a hearing system that provides a hearing before the Medicaid agency (DHHS) and which meets the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970).

42 C.F.R. § 431.220(a)(1) provides that a State agency must grant an opportunity for a hearing to a Medicaid participant if an applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness.

Finally, 42 C.F.R. §431.223 provides the agency may deny or dismiss a request for a hearing if the applicant withdraws the request in writing; or the applicant fails to appear at a scheduled hearing without good cause.

South Carolina's regulations governing fair hearings are set forth in S.C. Regs. 126-150, *et seq.* Specifically, Reg. 126-154 grants hearing officers the following authority:

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

(emphasis added).

The Goldberg Court stated that “[t]he fundamental requisite of due process of law is the *opportunity* to be heard.” Goldberg v. Kelly, 397 U.S. at 267 (internal citations omitted) (emphasis added). To comply with this fundamental due process requirement, the Court stated that the aggrieved “should have timely and adequate notice detailing the reasons for a proposed termination, and an effective *opportunity* to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally.” Id. (emphasis added).

Since Goldberg, however, the Court has refined its position regarding the fair hearing process and due process requirements. For example, the United States Court of

Appeals for the Sixth Circuit noted that the U.S. Supreme Court has since explained that the “due process requirement that the government provide a hearing before the termination of benefits turns on the sensible fact/law dichotomy that CMS, the State and Benton have drawn.” Rosen v. Goetz, 410 F.3d 919, 928 (6th Cir. 2005) citing Codd v. Velger, 429 U.S. 624, 627 (1977). In order for “the hearing mandated by the Due Process Clause [] to serve any useful purpose, there must be some factual dispute . . .” Id.

In applying the rationale set forth above, the Rosen court concluded that Tennessee’s Medicaid fair hearing procedures, which after an initial review and adverse determination would require the effected Medicaid recipients to provide information and at all points permitted a request for a hearing if a beneficiary presented a “valid factual dispute” about their continued eligibility for coverage, complied with due process requirements. Rosen, 410 F.3d at 929.

Similarly, in the present case, Waddle was given two (2) opportunities to state her intention with regard to pursuing the appeal, seeking a fair hearing, and presenting evidence of medical necessity prior to the fair hearing pursuant to a Prehearing Conference Order. Appellant failed to provide the requested information by the first due date and simply did not respond by the second due date. Although Goldberg provides the “opportunity” for a participant to be heard, it is clear under the present facts that Waddle abandoned the opportunity that was afforded to her by failing to provide the information requested.

Moreover, the South Carolina Supreme Court has determined that “[o]ne cannot complain of a due process violation if he has recourse to a constitutionally sufficient administrative procedure but merely declines or fails to take advantage of it. Zaman v.

S.C. State Bd. of Med. Examiners, 305 S.C. 281, 285, 408 S.E.2d 213, 215 (1991)

(identifying the due process requirements set forth in Goldberg in reaching its decision).

As previously stated, Waddle simply failed to take advantage or declined to take advantage of the fair hearing process by refusing to provide information requested from the hearing office in a Prehearing Conference Order.

Finally, in the cases of Mims v. S.C. Dept. of Health and Humans Svcs., Docket No. 07-ALJ-08-0082-AP (S.C. ALC 2007) and Brown v. S.C. Dept. of Health and Human Svcs., Docket No. 12-ALJ-08-0067-AP (S.C. ALC 2012), the ALC discussed the requirements of 42 C.F.R. § 431.223. In Mims, the hearing officer dismissed the appeal due to the participant's failure to timely provide further information requested in a pre-hearing Order. In Brown, the hearing officer dismissed the appeal due to the participant's failure to provide a more definite statement of the issues on appeal. Both were procedural dismissals prior to a fair hearing.

In Mims, the appellant/participant raised the same arguments present in this case; specifically, that a hearing officer may only dismiss a fair hearing request if the participant withdraws the request in writing, or fails to attend a hearing without good cause. While the ALC acknowledged those situations in which a hearing officer *may* dismiss appeals, citing Sunset Cay, LLC v. City of Folly Beach, 357 S.C. 414, 593 S.E.2d 462 (2004), the court determined that "may" was permissive and not mandatory.

The ALC opined,

the federal regulation [42 C.F.R. § 431.223] is not so comprehensive that it preempts the state from passing regulations which are not contradictory. In this instance the state has promulgated regulations that provide additional grounds for dismissal and can be applied harmoniously with the federal regulations.

[DHHS] can promulgate regulations governing the administration of hearings so long as they do not conflict with the federal regulations. [internal citation omitted] The language of 42 C.F.R. § 431.223 and 27 S.C. Code Ann. Regs. 126-154 do not contradict each other. Accordingly, the Hearing Officer had the authority to dismiss Mims's appeal for failure to comply with his November 30 Order.

Mims, Docket No. 07-ALJ-08-0082-AP.

For the reasons set forth in Mims, there is substantial evidence in the record to support the hearing officers Order of Dismissal and, therefore, the Order should be affirmed.

For the reasons set forth herein, DHHS respectfully requests that the appeal either be dismissed as not preserved or, in the alternative, that the hearing officer's Order of Dismissal be affirmed.

III. WADDLE'S REMAINING ARGUMENTS ARE NOT PRESERVED FOR REVIEW (WADDLE'S ISSUES 3, 4 AND 5)

In its October 11, 2013 Order, the ALC determined that all of the issues presented on appeal, except the hearing officer's Order of Dismissal, involved the same or substantially the same claims as those arising in a pending proceeding between the same parties and, therefore, even if properly raised in this case would be subject to dismissal under at Rule 12(b)(8), SCRCF theory. Regardless, the ALC went on to state that Waddle failed to present a proper record of these issues on appeal but instead attempted to improperly create a record through incorporating exhibits from the companion proceeding in her Initial Brief. [R. pp. 7-8]. Citing to Administrative Law Court Rule 36, the ALC concluded that there were no facts in the Record to consider regarding any issue other than the Order of Dismissal. Id.

“Issues not raised to and ruled on by the agency are not preserved for judicial consideration.” Brown v. S. Carolina Dep’t of Health & Envtl. Control, 348 S.C. 507, 519, 560 S.E.2d 410, 417 (2002); Carson v. South Carolina Dep’t of Natural Res., 371 S.C. 114, 120, 638 S.E.2d 45, 48 (2002) (stating that a court sitting in appellate capacity may not consider issues not raised or ruled on by administrative agency); see also Al-Shabazz v. State, 338 S.C. 354, 527 S.E.2d 742 (2000); Kiawah Resort Assoc. v. South Carolina Tax Comm’n, 318 S.C. 502, 458 S.E.2d 542 (1995). If an issue is raised to, but not ruled upon by the agency, nothing in the South Carolina Administrative Procedures Act (“APA”) prevents a party from seeking reconsideration or requesting a hearing. Kiawah Resort Associates, 318 S.C. at 506, 458 S.E.2d at 544. In fact, the APA specifically acknowledges a party’s right to seek reconsideration of a final agency decision. Id. citing S.C. Code Ann. § 1-23-380 (“proceedings for review are instituted by serving and filing notice of appeal . . . within thirty days after the final decision of the agency *or, if a rehearing is requested*, within thirty days after the decision is rendered”) (emphasis added).

In the present appeal, the remaining issues raised on appeal by Waddle were not raised to or ruled upon by the hearing officer. Moreover, Waddle did not file a Motion for Reconsideration requesting a ruling on the arguments, assuming *arguendo* they were raised. Cf. Elam v. S. Carolina Dep’t of Transp., 361 S.C. 9, 24, 602 S.E.2d 772, 780 (2004) (stating a party *must* file a Rule 59(e), SCRCRCP, Motion to Alter or Amend when an issue or argument has been raised, but not ruled on, in order to preserve it for appellate review).

Moreover, as stated by the ALC, there are no facts in the Record on Appeal upon which this Court can base its decision. S.C. Code § 1-23-380 (stating appellate review must be confined to the record).

As these arguments were neither discussed, addressed nor ruled upon in the Order of Dismissal, they are not preserved for appellate review and, therefore, the appeal should be dismissed or, in the alternative, the Order of Dismissal affirmed.

CONCLUSION

For the reasons set forth, Respondent respectfully requests the Court dismiss the appeal as the issues are not preserved or, in the alternative, to affirm the agency's Order of Dismissal.

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

Case No. 2013-002415

Brook Waddle,

Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent.

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Introduction. In *Altria Grp., Inc. v. Good*, the United States Supreme Court recognized that:

Article VI, cl. 2, of the Constitution provides that the laws of the United States "shall be the supreme Law of the Land; ... any Thing in the Constitution or Laws of any state to the Contrary notwithstanding." Consistent with that command, we have long recognized that state laws that conflict with federal law are "without effect."

129 S. Ct. 538, 543 (2008), quoting *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981).

Supremacy Clause. It is undisputed that the DHHS hearing officer dismissed Appellant's fair hearing appeal based solely upon state regulation R. 126-154 and South Carolina Code § 44-6-90, which authorizes DHHS to "promulgate regulations to carry out its duties." R. 2, 11. Order dated April 4, 2013. The hearing officer's Order fails to even mention any federal statute or regulation and it is clear that the hearing officer did not base her decision on any provision of the Medicaid Act or regulations promulgated by the federal Medicaid Agency, C.M.S. (Center for Medicare and Medicaid Services). It is also obvious that the state regulation the hearing officer relied upon is in direct in conflict with federal law. Nothing in South Carolina Code § 44-6-90 can empower DHHS to ignore the requirements of the Medicaid Act while it accepts federal funding for the program. Respondent continues to argue on page 7 of its Brief that this state

regulation grants hearing officers powers that are expressly forbidden by the regulations promulgated by CMS. The state regulation which provides that "A Hearing Officer has the authority, among other things to: ...dismiss any appeal for failure to comply with the requirements under this Subarticle" directly conflicts with 42 C.F.R. 431.223.

While it is true that Medicaid is an optional program, once the State of South Carolina elected to participate in and accepted federal funding, it became obligated to "comply with all federal Medicaid laws and regulations." *Doe v. Kidd I*, 501 F.3d 348, 351 (4th Cir. 2007), citing *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). As the state agency responsible for administering the Medicaid program in South Carolina, the South Carolina Department of Health and Human Services ("DHHS") is prohibited by federal law from delegating the authority to exercise administrative discretion in the administration or supervision of the Medicaid program. 42 C.F.R. 431.10(e)(1). DHHS is responsible for errors of its contracted agent, Apria, under this regulation.

Any state law or regulation which conflicts with the requirements of the Medicaid Act violates the Supremacy Clause and is unenforceable. In *Wos v. E.M.A.*, the United States Supreme Court ruled that a North Carolina statute allowing the State Medicaid Agency to recover from tort judgments for repayment

of the State's Medicaid lien was preempted by federal law. 133 S. Ct. 1391, 1398

(2013). The Supreme Court unambiguously ruled in that case that:

Under the Supremacy Clause, "[w]here state and federal law 'directly conflict,' state law must give way." *PLIVA, Inc. v. Mensing*, 564 U.S. —, —, 131 S.Ct. 2567 2577, 180 L.Ed.2d 580 (2011). The Medicaid anti-lien provision prohibits a State from making a claim to any part of a Medicaid beneficiary's tort recovery not "designated as payments for medical care." *Ahlborn*, *supra*, at 284, 126 S.Ct. 1752. North Carolina's statute, therefore, is pre-empted if, and insofar as, it would operate that way.

Id. In *Antrican v. Odom*, the Court of Appeals for the Fourth Circuit ruled that the State's "novel position" that the Medicaid Act was not "supreme" law was "at odds with existing, binding precedent." 290 F.3d 178, 188 (4th Cir. 2002). In that case, the Fourth Circuit relied upon the opinion of the United States Supreme Court in *Harris v. McRae*, where the Supreme Court instructed the States that: "[a]lthough participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of Title XIX [the Medicaid Act]." 448 U.S. 297, 301, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980). In *Antrican*, the Fourth Circuit ruled that "for those States that opt to participate in the program, the requirements of the Medicaid Act are mandatory." *Id.*

Respondent stated on pages 2 and 3 of its Brief that Waddle's request for an oximeter cable was denied, not due to any fault of Waddle, but because it's agent,

Apria, "did not provide any supporting clinical information with the request." On page 5, Respondent admits yet another error made by its agent, when it acknowledges that Apria, after failing to provide necessary information, "incorrectly coded the request for the oximeter cable..." Instead of apologizing to Waddle and fixing its error, first DHHS sent Waddle - a person who cannot speak, walk, feed herself or even take a sip of water without assistance - around in circles, refusing to provide either the equipment or the evidentiary hearing the Constitution of the United States and the Medicaid Act guarantees. Contrary to Respondent's argument that the only relief that may be provided is to remand the issue of payment for the cable, Waddle respectfully requests that this Court take the necessary action to force DHHS to end the agency's systemic unconstitutional practice of violating the due process rights of Waddle.

Waddle's case was dismissed by the DHHS hearing officer when she attempted to exercise her rights to due process, just as the lower court had done in *Flemming v. South Carolina Electric and Gas Company*, 239 F.2d 277 (4th Cir., 1956). Sarah Mae Flemming was "a Negro woman" who brought a lawsuit against the South Carolina Electric and Gas Company when a SCEG bus driver ordered her to go to the back of the bus in accordance with the segregation statutes of South Carolina, Code 1952, §§ 58-1491 to 58-1496. *Id.* at 278. The district Judge

dismissed Sarah's case *on the ground that the State statutes were valid*, just as the hearing officer dismissed Waddle's case based her interpretation of state law and regulation. (Emphasis added.) The Court of Appeals for the Fourth Circuit remanded Sarah's case, but the district court, on remand, once again dismissed Sarah's case. *Id.* at 278. Finally, on the second appeal to the Fourth Circuit, that court ruled that the "separate but equal" doctrine had been clearly repudiated by the decisions of the United States Supreme Court. *Id.* Sarah was again sent back to the district court for trial in a hostile court in 1956.

DHHS has been no more receptive to the claims Waddle has made during in the twenty-first century than the courts in South Carolina were to the civil rights of black citizens more than fifty years ago. Waddle prays for an order that will not send her back into that Executive Branch abyss, but one that will find that Waddle is the prevailing party in this action, a decision that will bind the agency and require hearing officers who hear Waddle's appeals in the future to comply with the clear and unambiguous requirements set forth in the federal fair hearing regulations. 42 U.S.C. 1396a(a)(3) and 42 C.F.R. 431.220 et. seq. require the agency to provide an evidentiary hearing, except where one of the limited exceptions contained at 42 C.F.R. 431.223 exists. (None of which exist in this case.) Those federal regulations provide very explicit criteria which must be met

during a hearing and require that the hearing officer base agency decisions exclusively on evidence produced at the hearing. While many of the provisions in the Medicaid Act are difficult to understand, the regulations upon which Waddle relies are simple to read and to follow, and DHHS has blatantly and repeatedly ignored them with impunity. As Respondent argues on page 5, Waddle finally received the oximeter cable that initiated this civil action. But, just as Sarah Mae Flemming was at risk of having her civil rights denied the next time she stepped onto a city bus, Waddle will continue to rely upon services and equipment to be provided by DHHS. The risk of injury to Waddle, however, is not that she will have to walk instead of riding the bus or face insults and hostility. Waddle cannot walk. *Waddle v. DHHS* (DHHS Order dated November 19, 2013). She cannot leave the house, except to be transported by ambulance to medical appointments. Because her medical condition is so fragile and complex, the risk to Waddle is the risk of death if she does not receive the services and equipment she needs from DHHS in a timely manner. The actions of the agency in this case, coupled with the factual history in *Waddle v. DHHS* in the November 19, 2013 order issued by Elizabeth Hutto demonstrate that these violations of federal law are subject to

repetition, yet they will continue to evade review.¹

Evidence introduced at hearing. Waddle requests that this Court's order prohibit DHHS from issuing decisions on any grounds other than evidence "introduced at the hearing," as required by 42 C.F.R. 431.244(a). This federal regulation provides that "Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing." Waddle requests a ruling that it is impossible to comply with 42 C.F.R. 431.244(a) without providing a hearing. She asks that this Court issue a ruling enjoining DHHS from denying her right to bring witnesses, to establish all pertinent facts and circumstances orally, to present an argument without interference and to confront and cross-examine the State's witnesses, as required by 42 C.F.R. 431.242 and *Goldberg v. Kelly*, 397 U.S. 254 (1970).

Notice. Waddle also respectfully requests a ruling from this Court requiring DHHS to comply with the clear and unambiguous notice requirements contained in 42 C.F.R. 431.210.² R. 160. Nowhere in the "notice" sent to Waddle did

¹ This Court may take judicial notice of that decision under Rule 201 of the South Carolina Rules of Evidence.

² In Appellant's brief, she refers to *L.S. v. Delia*, where the district court found notices to be insufficient. 5:11-cv-354 (NCED March 29, 2012). On appeal, the Fourth Circuit later found the notices at issue in that case to be sufficient, but that case involved programmatic changes not at issue in this case, which deals with the medical necessity for a single individual. *Pashby v.*

Respondent admit that it was not the fault of Waddle, a severely disabled person who has quadriplegia, but the fault of its own agent, Apria, that Waddle did not receive the oximeter cable. Respondent's Brief at 5. It is undisputed that the notice did not contain the "specific regulations" or change in federal or state law that required the action, a requirement clearly mandated in 42 C.F.R. 431.210(c). Without this information, it is impossible for a Medicaid participant to prepare her appeal when DHHS again terminates, denies or fails to provide services or equipment with reasonable promptness.

The issue of what must be included in a "fair hearing" notice was discussed in *K.W. v. Armstrong*, where the Idaho federal district court found the State's notices to be insufficient. Case No. 1:12-cv-00022 and 3:12-CV-58 (Idaho D.C. March 24, 2014). In an earlier decision, the district court found that the notices "must contain . . . [t]he reasons for the intended action" and "detail the reasons for a proposed termination" ... "sufficiently enough for a recipient to challenge both the application of the law to their factual circumstances and the 'factual premises' of the state's action." *Id.*, citing *Goldberg v. Kelly*, 397 U.S. 254, 267-268 (1970). The court held that the explanation in the notice itself "must be more than a 'general explanation' or 'conclusory statement,' and must provide at least 'a brief

Delia, 709 F.3d 307 (4th Cir. 2013).

statement of [the decision's] factual underpinnings." Id., citing *Barnes v. Healy*, 980 F.2d 572, 579 (9th Cir. 1992). As in that case, DHHS failed to provide "an explanation for any change." Id. Where the notice "gives participants nothing more than the general explanation that several factors may have affected" their benefits, that "lack of specificity runs afoul of due process because *Goldberg* requires a notice tailored to the individual." 397 U.S. at 267-68 ("[Due process] require that a recipient have timely and adequate notice detailing the reasons for a proposed termination . . ." (emphasis added)). The notice has to "give a participant the opportunity to understand 'the factual premise' of his or her 'particular case.'" Id.

In *K.W.*, the Idaho district court discussed *Ortiz v. Eichler*, where the Third Circuit decided "the extent of a pre-hearing notice required to be given under the due process clause" by Delaware when "denying or terminating Aid to Families with Dependent Children (AFDC), Food Stamps and Medicaid benefits." 794 F.2d 889, 890 (3rd Cir. 1986). There, the Third Circuit held that notices must "at a minimum, provide a detailed individualized explanation of the reason(s) for the action being taken which includes, in terms comprehensible to the claimant, an explanation of why the action is being taken and, if the action is being taken because of the claimant's failure to perform an act required by a regulation, an

explanation of what the claimant was required by the regulation to do and why his or her actions failed to meet this standard..." Nothing in the notice sent to Waddle informs her of the reasons, now admitted, by DHHS, nor does the notice inform her of the regulation and statute now relied upon to justify the failure to provide the device and to dismiss her appeal.

Respondent errs in its arguments on page 5 that there is "no actual controversy." The existence of a controversy is evident from the fact that Waddle filed an appeal in 2007 and that she has yet to obtain judicial review of the agency's decision to deny services ordered by her physician eight years ago in that case. *Waddle v. DHHS* (DHHS November 19, 2015). The issues Waddle raised are subject to repetition, yet they have evaded review and they are likely to recur, if DHHS can force Medicaid participants into protracted litigation costing more than the equipment and services they deny - and costing taxpayers and the court system for years of appeals.

Dismissal of appeals. Respondent's arguments beginning on page 5 blatantly ignore the requirement at 42 C.F.R. 431.223 prohibiting DHHS from dismissing an appeal without providing a hearing except where the participant requests dismissal or "fails to appear at a scheduled hearing without good cause." In *State of South Carolina v. Katzenbach*, the United States Supreme Court struck

down impediments that the State of South Carolina had “designed to prevent Negroes from voting.” 383 U.S. 301, 310 (1966). Like the “grandfather clauses, property qualifications, ‘good character’ tests, and the requirement that registrants ‘understand’ or ‘interpret’ certain matter” in *Katzenbach*, the State of South Carolina now imposes insurmountable requirements before “fair hearings” are granted by DHHS to impoverished disabled Medicaid participants. It is notable that this is not the first time DHHS dismissed Waddle’s appeals without providing an evidentiary hearing. *Waddle v. DHHS*, November 19, 2013.³ Once again, nearly forty years after *Katzenbach*, the State of South Carolina needs to have the Judicial Branch to instruct the Executive Branch agencies that federal law preempts any state law or regulation that conflicts with federal law or the United States Constitution.

Respondent’s arguments on page 7, that Reg. 126-154 controls over the clear and unambiguous requirements of the mandates requiring DHHS to provide a fair hearing and to render a decision “exclusively” on evidence presented at an

³ DHHS dismissed Waddle’s fair hearing appeal without providing an evidentiary hearing, requiring her to file an appeal with the Administrative Law Court on her 2007 appeal. On remand, the DHHS hearing officer upheld the decision of the agency, requiring a second appeal to the Administrative Law Court. *Waddle v. DHHS*, November 19, 2013. Waddle filed her third appeal with the Administrative Law Court more than a year ago when DHHS refused to comply with the order of its hearing officer, but that Executive Branch agency has not issued an order appealable to the Judicial Branch.

evidentiary hearing cannot prevail. In *Katzenbach*, the State argued that it gave negro voters the "opportunity" to vote once they jumped through hoops that violated the federal Voting Rights Act. Like the victims of illegal practices that kept black citizens from voting, DHHS has prevented Medicaid participants from exercising their right to due process and failed to grant evidentiary hearings in a timely manner meeting the requirements of 42 C.F.R. 431.242 under the pretext that the participant was given the "opportunity" for a hearing and failed to perfect it.

Respondent's reliance upon *Rosen v. Goetz* is misplaced. 410 F.3d 919, 928 (6th Cir. 2005). Unlike Waddle's case, that Tennessee case involved a change in law, not a factual dispute that required consideration of medical necessity for an individual Medicaid participant. In any event, the reductions at issue in *Rosen* were subsequently overturned in *Crabtree v. Goetz*. Case No. 3:08-0930 (M.D. Tenn. 2008). On page 9, Respondent argues that Waddle declined or failed to take advantage of her due process rights, but this appeal is pending precisely because Respondent attempted to exercise those rights, but DHHS denied her federally mandated right, guaranteed by the Constitution of the United States of America, to an evidentiary hearing. On page 9, Respondent also cites *Brown v. S.C. Dept. of Health and Human Services* in support of its arguments, but in that case, this

Court ruled that DHHS erred by dismissing his appeal without providing a fair hearing on the merits of his case and remanded Brown's case for an evidentiary hearing required by CMS regulations. 393 S.C. 11709 S.E.2d 701 (S.C.Ct.App. 2011). On remand, DHHS agreed not to contest Brown's right to receive the services at issue in that case. 13 ALJ 08-0159 (March 7, 2014). (Although Appellant alleged that the services were still not provided. This Court may take judicial notice of its own docket.)

Issues Respondent's Brief failed to address. Respondent has failed to address in its brief Waddle's claims that DHHS has violated her rights under the Americans with Disabilities Act (ADA). Appellant's Brief at 9, 20 and 21. Waddle has met her own *prima facie* burden, by proving that she is a disabled person, the State has determined that she may be served in the Community and that she chooses to receive services there. Appellant's Brief at 20. But, Respondent makes no attempt whatsoever discuss in it's brief its own burden of proving that providing the oximeter cable and complying with the clear and unambiguous federal "fair hearing" regulations would fundamentally alter the State's system. *Olmstead v. L.C.*, 527 U.S. 581 (1999) and *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013). Respondent did not even mention the controlling case on this issue, *Stogsdill v. DHHS*, where this Court ruled that DHHS had violated the Americans

with Disabilities Act. Appellate Case No. 2013-000762, Opinion No. 5271 (S.C.Ct. App. September 10, 2014). That case was issued approximately three months after Waddle filed her Initial Brief in this Court.

Respondent also failed to address the issues raised by Appellant regarding the hearing officer's refusal to order an independent medical assessment and her failure to base her decision on medical evidence from a qualified medical source. Appellant's Brief at 16.

Evidence in record. Respondent's argument on page 10 that "there is substantial evidence in the record to support the hearing officer's Order" is simply not supported by the record or the law. First, federal law is clear that there can be no evidence upon which the hearing officer may legally rely where no hearing has been provided. This is because 42 C.F.R. 431.244(a) requires DHHS to base its decision "exclusively" on evidence introduced at the hearing. The argument that "Waddle failed to present a proper record" also fails, because Waddle repeatedly has asked the Executive Branch to follow the law and to provide her with the evidentiary hearing required by 42 C.F.R. 431.242 where both sides may properly "present a proper record." DHHS cannot deny Doe's Constitutional right to a hearing, then complain that Waddle failed to develop a record.

Ripeness and mootness. Likewise, Respondent's argument on page 11 that the issues Waddle "raised on appeal" were not "raised or ruled upon by the hearing officer" cannot be blamed on Waddle. On the contrary, Waddle raised issues in her appeal to DHHS and it was the fault of the hearing officer that she chose to ignore Waddle's claims made in the appeal, ignore the federal law and refuse to rule upon the issues Waddle raised. A motion for reconsideration is not required in fair hearing appeals or the Administrative Law Court. Rule 40 of the South Carolina Rules of the Administrative Law Court specifically provides that "A motion for rehearing is not a prerequisite to filing a notice of appeal from the decision of the administrative law judge." As discussed in Waddle's initial brief, 42 C.F.R. 431.244(f) requires the State to issue a final administrative hearing within 90 days. *Shakhnes v. Berlin*, 689 F.3d 244, 254 (2d 2012).⁴ Appellant's

⁴ In *Shakhnes*, cited on page 8 of Appellant's Brief, the Second Circuit discussed the legislative history of 42 C.F.R. 431.244(f) as follows:

We begin with 45 C.F.R. § 205.10, the predecessor to 42 C.F.R. § 431.244. Section 205.10 was entitled "Fair hearings." See Fair Hearings, 35 Fed.Reg. 8448 (May 29, 1970). Subsection (11) of § 205.10 provided that "[p]rompt, definitive and final administrative action will be taken within 60 days from the date of the request for a fair hearing, except where the claimant requests a delay in the hearing." Id. at 8449. The time frame for "[p]rompt, definitive, and final administrative action" was later extended to 90 days. See Methods for Determination of Eligibility, 38 Fed.Reg. 22,005, 22,008 (Aug. 15, 1973). The relevant agency explained the need for the change as follows: "In view of the difficult position facing States with substantially increased hearing caseloads, the 60-day period is considered insufficient for the orderly processing of cases." Id. at 22,006 (emphasis added). The agency concluded that "[n]inety days for processing hearings" was "a more realistic time frame." Id. (emphasis added). And the agency described the

Brief at 8. It would be impossible to comply with this federal requirement, and to issue a final decision within 90 days, if the appellant were required to file a motion to alter or amend or reconsider.

Respondent is correct that the oximeter cable has now been provided, but it is not correct in its assertion that Waddle's case is moot. R.Brief at 4 and 5. DHHS has argued to state and federal courts that the only remedy Medicaid participants have is in the "fair hearing" process, and that they may not litigate violations of the Medicaid Act in federal court. *Doe v. Kidd I, supra*. This is a classic case where there is a reasonable expectation that the same complaining party will be subjected to the same action again and would be unable to resolve the issue (by DHHS waiting months or years, then providing the equipment or services) because of the duration of the action, as was the case of pregnancy in *Roe v. Wade*. 410 U.S. 113 (1973). The second exception to the mootness doctrine is that a case will not be dismissed where a plaintiff's claim has been mooted by a defendant's voluntary cessation of allegedly improper behavior. *Doe v. Kidd I, supra*. This

change as an "[e]xtension from 60 to 90 days for hearing decisions." *Id.* (emphasis omitted).

The 90 day requirement is also discussed in *Doe v. Kidd I and II, supra* and 419 Fed.Appx. 411, 414 (2011).

"voluntary cessation" exception provides that "a defendant's voluntary cessation of a challenged practice does not deprive a federal court of its power to determine the legality of the practice." *Friends of the Earth, Inc. v. Laidlaw Environmental Services*, 528 U.S. 167, 189 (2000). Except for this exception, courts would be "compelled to leave the defendant free to return to his old ways." *Id.* Voluntary conduct moots a case only in the rare instance where "subsequent events made it 'absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur.'" *Joes v. City of Lakeland*, 224 F.3d 518, 529 (6th Cir.2000) (*en banc*) (quoting *Friends of the Earth, Inc.*, *supra*, 528 U.S. at 189). Whenever there is a risk that the defendant will "return to his old ways," where the plaintiff continues to have a stake in the outcome, the case is not moot. *Doe v. Kidd I*, *supra*. Indeed, the party asserting mootness has the "heavy burden of persuading the court that the challenged conduct cannot reasonably be expected to start up again." *Friends of the Earth, Inc.*, *supra*, 528 U.S. at 189. Respondent has failed to meet that burden in this case. The question is not whether Brook is at risk of DDSN refusing to provide an oximeter cable again - the next time, it may be incontinence supplies or another device or service. But what is sure is that Waddle will continue to be at risk of services and equipment being denied by an agency that appears to have seemingly unending funds to pay for litigation. The Executive

Branch has demonstrated a will to win at all costs, with total disregard for the consequences to Waddle and there is no indication of intention to cease its wrongful conduct of ignoring federal law.

Conclusion. Waddle requests that this Court find that DHHS has acted without substantial justification by:

- (1) Failing to issue notices that comply with the clear and unambiguous notice requirements of 42 C.F.R. 210 and the due process requirements of *Goldberg v. Kelly* and Waddle respectfully renews her request that the Court issue an order declaring Respondent's notice in this case to be defective and unconstitutional and requiring DHHS to comply with that regulation and the due process standards established in *Goldberg. Supra.* Appellant's Brief at 16, 19 and 20.
- (2) Failing to provide fair hearings required by the regulations contained in 42 C.F.R. 431.242 and *Goldberg* and Appellant requests an order enjoining the State from continuing to violate fair hearing regulations and the due process rights of Waddle. Appellant's Brief at 16.
- (3) Dismissing "fair hearing" appeals when the appellant has not requested dismissal nor failed to appear at a hearing and failing to base hearing

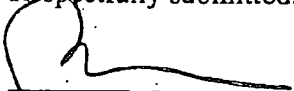
decisions exclusively on evidence presented at the fair hearing. Appellant's Brief at 11-12 and 16.

- (4) Basing hearing decisions on state regulations and statutes that are preempted by federal law.
- (5) Failing to base medical necessity decisions on the opinions of qualified medical sources and refusing to order an independent medical assessment when requested by Appellant. Appellant's Brief at 18.
- (6) Violating the Americans with Disabilities Act by failing to provide necessary equipment needed to allow Waddle to live in the least restrictive setting. Appellant's Brief at 23.

Waddle requests an order finding that the state statute and regulations upon which Respondent relied are preempted by the Medicaid Act and the regulations discussed in Appellant's Briefs and requiring DHHS to comply with those federal laws. Appellant believes that providing the lower tribunals any discretion on remand would serve no useful purpose and would only waste more scarce resources of Waddle and the judicial system, as this case would weave once again for years through the Executive Branch, as is evident from the appeal Waddle filed in 2007, still pending in the Judicial Branch. Opting not to take this opportunity to

declare the federal law and to establish consequences for violating federal laws and regulations will only feed the fire and send a terrible message to other Medicaid participants that state agencies can violate that law with impunity, disregarding the financial and medical costs to the most vulnerable citizens of our State. Appellant requests that the Court also award such other relief as is fair and just under the circumstances. Waddle further requests that the Court issue an order finding that Waddle is the prevailing party, that DHHS has acted without substantial justification and ordering DHHS to pay legal fees and costs.

Respectfully submitted.



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**THIS OPINION HAS NO PRECEDENTIAL VALUE. IT SHOULD NOT BE
CITED OR RELIED ON AS PRECEDENT IN ANY PROCEEDING
EXCEPT AS PROVIDED BY RULE 268(d)(2), SCACR.**

**THE STATE OF SOUTH CAROLINA
In The Court of Appeals**

Brook Waddle, Appellant,

v.

South Carolina Department of Health and Human
Services, Respondent.

Appellate Case No. 2013-002415

Appeal From The Administrative Law Court
Ralph King Anderson, III, Administrative Law Judge

Unpublished Opinion No. 2016-UP-109
Submitted February 1, 2016 – Filed March 2, 2016

APPEAL DISMISSED

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Columbia, for Respondent.

PER CURIAM: Affirmed pursuant to Rule 220(b), SCACR, and the following authorities: *Sloan v. Greenville Cty.*, 380 S.C. 528, 535, 670 S.E.2d 663, 667 (Ct. App. 2009) (stating an appellate court will not pass judgment on moot and academic questions or adjudicate a matter when no actual controversy capable of specific relief exists); *Sloan v. Friends of the Hunley, Inc.*, 369 S.C. 20, 26, 630 S.E.2d 474, 477 (2006) (stating a moot case exists when "a judgment rendered by the court will have no practical legal effect upon an existing controversy because an intervening event renders any grant of effectual relief impossible for the reviewing court"); *Sloan v. Dep't of Transp.*, 365 S.C. 299, 303, 618 S.E.2d 876, 878 (2005) (stating an appellate court can accept jurisdiction, despite mootness, if the issue is capable of repetition but evading review); *Friends of the Hunley, Inc.*, 369 S.C. at 27, 630 S.E.2d at 478 ("However, the action must be one [that] will truly evade review."); *City of Charleston v. Masi*, 362 S.C. 505, 508-09, 609 S.E.2d 301, 303 (2005) ("Regarding the exception that a court can take jurisdiction, despite mootness, if the issue raised is capable of repetition but evading review, we find that while the questions involved could arise again, the questions will not 'usually become moot' before they can be reviewed.").

APPEAL DISMISSED.¹

FEW, C.J., and SHORT and THOMAS, JJ., concur.

¹ We decide this case without oral argument pursuant to Rule 215, SCACR.

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

Case No. 2013-002415

Brook Waddle,

Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent.

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JUN 12 2015

SC Court of Appeals

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

Case No. 2013-002415

Brook Waddle Appellant,

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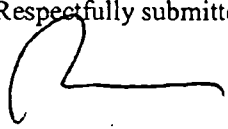
South Carolina Department of Health and Human Services.....Respondent.

PETITION FOR REHEARING/RECONSIDERATION
SUGGESTION FOR EN BANC HEARING

Petitioner, Brook Waddle, petitions the South Carolina Court of Appeals for a rehearing/reconsideration and hearing en banc of the court's recent decision in Brook Waddle v. South Carolina Department of Health and Human Services, Op. No. 2016-UP-109 (S.C.Ct. Ap. filed March 2, 2016).

The grounds for the petition for rehearing/reconsideration and hearing en banc are addressed in the supporting memorandum filed herewith and incorporated herein.

Respectfully submitted,



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March 17, 2016

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Ralph K. Anderson, III, Chief Administrative Law Judge

RECEIVED

MAR 17 2016

SC Court of Appeals

Case No. 2013-002415

Brook Waddle Appellant,

v.

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

MEMORANDUM IN SUPPORT OF
PETITION FOR REHEARING/RECONSIDERATION
SUGGESTION FOR *EN BANC* HEARING

Petitioner, Brook Waddle, respectfully petitions the South Carolina Court of Appeals for a rehearing/reconsideration of the court's recent decision in *Brook Waddle v. South Carolina Department of Health and Human Services*, Op. No. 2016-UP-109 (S.C.Ct. Ap. filed March 2, 2016). Petitioner requests that this Court reconsider its opinion and suggests that a hearing be scheduled to hear this case *en banc*, due to the public importance of the due process issues in this case.

In support of this Petition, Petitioner respectfully submits the following points that were overlooked or misapprehended by this Court.

Petitioner believes that the Court may have misconstrued this case as being solely about

whether an oximeter cable was belatedly provided to Petitioner, after this case reached the Administrative Law Court level. But, the issue in this case is far more important than that.

The issue in this case is about the process - and the denial of fundamental due process rights. It is about whether the Judicial Branch will enforce due process rights of the most vulnerable citizens of South Carolina and require DHHS to stop violating the Fourteenth Amendment and statutory rights of Medicaid participants, as required by 42 U.S.C. 1396a(a)(3) and federal rules and regulations interpreting that statute.

Who has standing to complain about the violations identified in Petitioner's brief, if Brook does not?

Persons who appear at a hearing do not, according to this Court's ruling in *Stogsdill v. DHHS*, 410 S.C. 273, 763 S.E.2d 638, 642 (S.C. App. 2014). In that case, this Court determined that the Medicaid participant's due process rights were not violated where he did not receive any notice of the reduction in services and was not informed, before the hearing, of the grounds upon which DHHS intended to argue at the hearing. *Stogsdill v. S.C. Dep't of Health & Human Servs.*, 410 S.C. 273, 763 S.E.2d 638, 642 (S.C. App. 2014). This Court found that Stogsdill "...suffered no prejudice in this case based on the inadequate notice of proposed changes..." but it did recognize that Medicaid participants "should have the fullest and fairest opportunity to exercise their rights." *Id.* This Court remanded Stogsdill's case to assess his needs, without applying the waiver caps. But no assessment has been performed twenty months after that decision was rendered and Stogsdill still has not received the services his physician ordered.

That was a repeat performance for DHHS. In 2009, in Stogsdill's first "fair hearing" appeal, after a hearing, the hearing officer remanded his case, ordering DHHS to assess his needs,

giving consideration to the order of his physician. DHHS ignored that order and did not reassess Stogsdill. Instead, without providing a notice, DHHS attempted to reduce his services to 28 hours a week. After Stogsdill filed a second notice of appeal, his providers were sent a notice terminating authorization for funding of the personal care services he was then receiving.

Stogsdill's attempt to enforce his due process claims in the federal court also hit a brick wall. *Stogsdill v. DHHS*, Case No. C/A No. 3:12-cv-0007 (S.C.D.C. November 10, 2014).¹ In that case, the federal court ruled that Stogsdill's only remedy for the State's violation of his due process rights was in the state court, because he did file a "fair hearing" appeal. Thus, even though the record closed in his state appeal in 2010, the court found that he had no right to litigate even those violations occurring after 2010 in federal court in a lawsuit filed in 2012. So, Stogsdill would be required to file a "fair hearing" appeal every time DHHS denied a requested service - then go through years of litigation in the Executive Branch.

So, persons who do file a fair hearing request have no rights to complain about the process, but neither do people who do not file an administrative appeal, according to the district court. The district court dismissed the due process claims of Stogsdill's co-plaintiff, Rob Levin, because he did not file a "fair hearing" appeal, saying:

Levin's only claim as to violation of his Due Process rights states, "Since January 1, 2010, [Levin's] services have been further reduced and reimbursement rates to his providers and physicians have been systematically reduced and these reductions in services and rates are likely to continue, yet Plaintiffs have been denied the opportunity for review because the state administrative system is futile and costs more than it would cost to buy the services, supplies, and equipment being appealed." (ECF 72, p. 27, ¶ 143). Levin never requested reconsideration of the reduction in services, nor did he appeal any reduction in services to SCDHHS, the proper agency to hear such requests. S.C. Code Ann. Regs. 126-152(B).

¹ An appeal has been filed in the Court of Appeals for the Fourth Circuit. *Stogsdill v. DHHS*, Case No. 13-1984.

There does not appear to be any evidence of alleged due process violations as to Levin. Levin's own failure to appeal the determination of a reduction in services because he deems the system to be "futile" does not give rise to a violation of his due process rights at the hands of the defendants. Therefore, the Court grants SCDHHS' motion for summary judgment as to the first cause of action alleged by Levin for violation of statutory and constitutional due process.

Stogsdill v. Keck at 26. So, Medicaid appellants, if they show up at a hearing have no due process rights. If they do not request a hearing and do not show up, they have no due process rights either. This is why Brook's case is so very important. She asked for a hearing and did not receive one. The notice provided to her does not meet the clear requirements of 42 C.F.R. 431.210. The equipment she needed was not provided with reasonable promptness and a final state administrative decision was not rendered within 90 days. She does not fall into either of the two above categories of people who the courts have said have no right to complain about DHHS' illegal actions.

This Court erred as a matter of law when it ruled that her case was moot. In *Sloan v. Greenville County*, 356 S.C. 531, 590 S.E.2d 338 (S.C. App., 2003), this Court ruled that it may take jurisdiction of a case, "despite mootness, if the issue raised is capable of repetition, but evading review." *Treasured Arts, Inc. v. Watson*, 319 S.C. 560, 564, 463 S.E.2d 90, 92 (1995) (Under the mootness doctrine of capable of repetition yet evading review, a case is not rendered moot when a challenged action was in its duration too short to be fully litigated prior to its completion and there was a reasonable expectation that the same complaining party would be subjected to the same action again.); *South Carolina Dep't of Mental Health v. State*, 301 S.C. 75, 76, 390 S.E.2d 185, 185 (1990) ([Although the issue presented was moot, "appeal was allowed because it raises a question that is capable of repetition, but which usually becomes moot

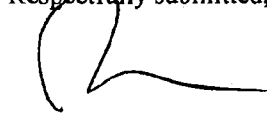
before it can be reviewed"); *Evans v. South Carolina Dep't of Soc. Servs.*, 303 S.C. 108, 110, 399 S.E.2d 156, 157 (1990) (addressing a moot question because the controversy presents a "recurring dilemma" which needed clarification for future guidance); 1 Am.Jur.2d Actions 50 (2003) (noting the general rule that "courts will not decide moot questions is subject to an exception where the question, though moot, is ... likely to recur and evade judicial resolution in the future"). The party bringing the action need only show the issue raised is capable of repetition and is not required to prove there is a "reasonable expectation" the issue [356 S.C. 555] will arise again. Byrd, 321 S.C. at 431-32, 468 S.E.2d at 864 (finding South Carolina has adopted the "lenient" approach to evading review analysis).

Brook's case is about a "recurring dilemma" which needs clarification for future guidance and it is capable of repetition, yet has evaded review. Not only is Brook subject to having small ticket items denied, or not provided with reasonable promptness, she continues to suffer from the due process violations complained of in this action. She has suffered the same fate Stogsdill suffers, because no state court has held DHHS accountable for complying with the federal notice, hearing and reasonable promptness mandate. She filed a fair hearing request in 2007 and is now back in the Administrative Law Court for the third time with no opportunity in nine years for judicial review in that appeal. In 2013, the hearing officer ordered DHHS to provide Brook nursing and personal care services and to pay her mother a sizeable amount of money. In June, 2014, Brook filed an emergency petition after DHHS refused to comply with the order of its own hearing officer. The Administrative Law Court still has taken no action on that emergency petition. Brook is still not receiving the services ordered by the hearing officer in 2013 and her mother still has not been paid the amount of money the DHHS hearing officer ordered her agency

to pay. Brook's claims in this appeal that DHHS systemically fails to comply with the reasonable promptness and due process mandates and the Americans with Disabilities Act are certainly not moot, as she personally continues to suffer the consequences for those violations of fundamental due process rights.

The fact that no final administrative decision has been issued in her first "fair hearing" appeal nine years after she filed her 2007 "fair hearing" appeal is conclusive evidence that DHHS continues to violate that federal mandate and that this appeal meets the "capable of repetition, yet evading review" standard set forth in *Sloan* and the other cases cited in this Court's order dismissing Brook's appeal. Brook prays that this Court will reconsider its decision to dismiss her appeal and schedule oral arguments, and suggests that an *en banc* hearing would be appropriate due to the extreme public importance of this case.

Respectfully submitted,



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March 17, 2016

The South Carolina Court of Appeals

Brook Waddle, Appellant,

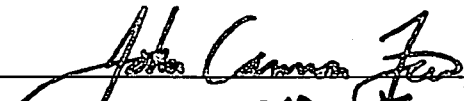
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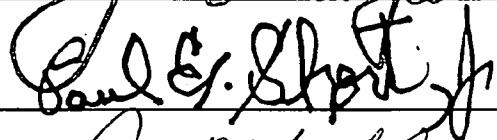
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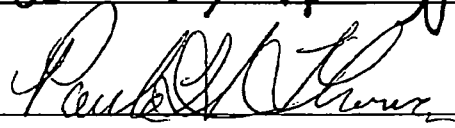
Appellate Case No. 2013-002415

ORDER

After careful consideration of the 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, the petition for rehearing is denied.



C.J.


J.


J.

Columbia, South Carolina

cc:

Patricia Logan Harrison, Esquire
Shealy Boland Reibold, Esquire
Kenneth C. Anthony, Jr., Esquire
Damon Christian Wlodarczyk, Esquire

FILED

June 10, 2016 