

THE STATE OF SOUTH CAROLINA  
In the Supreme Court

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS

Case No. 2013-002415

Brook Waddle,  
Petitioner,

v.

South Carolina Department of Health and Human Services  
Respondent.

**RECEIVED**

JUL 11 2016

**SC SUPREME COURT**

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PETITION FOR A WRIT OF CERTIORARI

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

Kenneth C. Anthony, Jr.  
PO Box 3565  
Spartanburg, South Carolina 29304  
803 582 2355  
[kanthony@anthonylaw.com](mailto:kanthony@anthonylaw.com)

Attorneys for Petitioner

Other Counsel of Record:

Damon Christian Wlodarczyk, Esq.  
PO Box 11412  
Columbia, South Carolina 29211

Shealy B. Reibold, Esq.  
South Carolina Department of Health  
and Human Services  
PO Box 8206  
Columbia, South Carolina 29202-8206

Attorneys for Respondent

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Kenneth C. Anthony, Jr.  
PO Box 3565  
Spartanburg, South Carolina 29304  
803 582 2355  
[kanthony@anthonylaw.com](mailto:kanthony@anthonylaw.com)

Attorneys for Appellant *Petitioner*

Other Counsel of Record:

Damon Christian Wlodarczyk, Esq.  
PO Box 11412  
Columbia, South Carolina 29211

Shealy B. Reibold, Esq.  
South Carolina Department of Health  
and Human Services  
PO Box 8206  
Columbia, South Carolina 29202-8206

Attorneys for Respondent

## TABLE OF CONTENTS

Questions Presented .....	1
Statement of the Case .....	1
Arguments .....	11
1. Did the South Carolina Court of Appeals err in determining that Petitioner's claims are moot? .....	11
2. Has the State violated 42 U.S.C. 1396a(a) and Petitioner's constitutional due process rights guaranteed by the Fourteenth Amendment by (1) failing to provide notices containing information required by 42 C.F.R. 431.210, (2) dismissing the appeal over Petitioner's objections without providing an evidentiary hearing, based on facts not introduced at that evidentiary hearing, and (3) striking information Petitioner incorporated by reference in identifying her issues on appeal, then determining Petitioner's case to be moot based on an affidavit presented by Respondent after her appeal was dismissed that was not included in the Record on Appeal? .....	15
3. Has the State violated the Medicaid Act by failing to issue a final administrative order and to provide services with reasonable promptness, in the amount, duration and scope needed to prevent institutionalization and hospitalization, and are these violations capable of repetition, yet they have evaded review? .....	22
4. Has the State violated the Americans with Disabilities Act through the continued application of binding norms not promulgated as regulations and failure to provide reasonable accommodations required by <i>Olmstead v. L.C.</i> and <i>Stogsdill v. DHHS</i> and are these violations ongoing? .....	24
Conclusion .....	25

## QUESTIONS PRESENTED

1. Did the South Carolina Court of Appeals err in determining that Petitioner's claims are moot?
2. Has the State violated 42 U.S.C. 1396a(a)(3) and Petitioner's constitutional due process rights guaranteed by the Fourteenth Amendment by (1) failing to provide notices containing information required by 42 C.F.R. 431.210, (2) dismissing the appeal over Petitioner's objections without providing an evidentiary hearing, and (3) striking information Petitioner incorporated by reference in identifying her issues on appeal, then determining Petitioner's case to be moot, based on an affidavit presented by Respondent after her appeal was dismissed that was not included in the Record on Appeal?
3. Has the State violated the Medicaid Act by failing to issue a final administrative order and to provide services with reasonable promptness, in the amount, duration and scope needed to prevent institutionalization and hospitalization, and are these violations capable of repetition, yet they have evaded review?
4. Has the State violated the Americans with Disabilities Act through the continued application of binding norms not promulgated as regulations and its failure to provide reasonable accommodations to Petitioner that are required by *Olmstead v. L.C.* and *Stogsdill v. DHHS*, and are these violations ongoing?

## STATEMENT OF THE CASE

**Introduction.** This is an appeal of the dismissal of Petitioner's administrative appeal for violations of the Medicaid Act and the Americans with Disabilities Act. *Brook Waddle v. DHHS*, Unpublished Opinion 2016 UP 109 (S.C. Ct. Ap. March 2, 2016) at R.p. 483. Petitioner qualifies to receive institutional care funded by Medicaid, but has elected to receive services at home through the Head and Spinal Cord Injury program administered by the South Carolina Department of Disabilities and Special Needs (DDSN) under contract with the South Carolina Department of Health and Human Services (DHHS). The program is described in the 2013 order of the DHHS hearing officer, Elizabeth Hutto, now a Deputy Director of DHHS at R.p. 14-15.

Petitioner initiated the appeal at issue in this case on January 30, 2013, alleging that the State has violated (1) her Constitutional and statutory due process rights, (2) certain mandates contained in the Medicaid Act and (3) the Americans with Disabilities Act. R.p. 152. In her 2013

administrative appeal, Petitioner incorporated by reference the allegations contained in her 2007 appeal, an appeal that remains frozen in the Executive Branch, without opportunity for judicial review for more than nine years now. R.p. 13. The hearing officer, the ALC and the South Carolina Court of Appeals erroneously adopted Respondent's theory of Petitioner's case. determining that the sole issue in this 2013 administrative appeal is the denial of payment for an oximeter cable, disregarding the other issues Petitioner clearly raised. R. 155, 159. Petitioner incorporated by reference in the 2013 appeal all allegations in the 2007 appeal and those made "during the course of these proceedings." R.p. 152. The lengthy history of those 2007 proceedings is described in *Waddle v. DHHS*, Order dated November 19, 2013 at R.p. 14-16.

**2007 Fair Hearing Appeal.** In that appeal, the DHHS hearing officer dismissed Petitioner's appeal without providing an evidentiary hearing. R.p. 15-16. After the Administrative Law Court (ALC) reversed, a "fair hearing" was held on April 14, 2009, upholding the decision of DDSN. R.p. 16. The ALC again reversed the agency on July 30, 2012, remanding Petitioner's case for a determination of the hours to be provided and the amount owed Petitioner's mother, and directing DHHS to pay for a speech device. R.p. 16.

A second hearing was held on October 25 and 31, 2012, but a decision was not issued by the agency until November 19, 2013. R.p. 16. DHHS filed a motion for reconsideration of its own agency's order, which was denied in a December 23, 2013 ruling finding:

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.

R.p. 358. The order restated that Respondent denied Appellant's due process rights and that

“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.’” R.p. 359. The hearing officer ruled that the reductions “were executed without prior written notice.” R.p. 359.

Both parties filed appeals with the South Carolina ALC and DHHS has refused to comply with the order of the hearing officer, leaving Petitioner without medically necessary nursing services and attendant care, and her mother without compensation that was awarded in 2013. R.p. 371-375, 379-385. On June 29, 2014, Petitioner filed an emergency petition requesting an order requiring DHHS to comply with the November 19, 2013 order. R.p. 369. The ALC has failed to act upon that emergency petition, services still have not been provided and a final state administrative order has not been issued more than nine years after Petitioner filed her appeal.

**2013 Fair Hearing Appeal.** While Petitioner’s 2007 appeal of denial of services ordered by her treating physicians remained mired in the Executive Branch, DHHS denied payment for an oximeter cable on January 9, 2013. R. 160. The oximeter cable is required to measure Petitioner’s oxygen level to determine whether oxygen must be administered. Respondent’s notice of denial stated that payment was denied because “supporting clinical information” was not provided R. 160. The notice did not contain information required by 42 C.F.R. 431.210. Id.

Instead of supplementing the record in the ongoing 2007 appeal, DHHS elected to address the 2013 complaints as a totally new appeal. The hearing officer issued a “Pre-hearing Conference Order” on February 5, 2013. R. 157. The hearing officer required the parties to confer and ordered DHHS to provide the hearing officer with a “summary of issues.” Id. She ordered Petitioner to file a “statement of intention to continue the appeal process and to attend a Fair Hearing.” Id. The parties conferred, as required by the order. R. 155.

On March 19, 2013, DHHS advised that the reason for the denial of payment for the oximeter cable was that DHHS was not provided necessary “supporting clinical information and a prescription for the device” within 48 hours.<sup>1</sup> Id. In its response, DHHS’ attorney deferred to Appellant’s counsel “to submit to the hearing officer any *additional* issues she wishes to raise at the hearing.” Id. (Emphasis added.) Also on March 19, 2013, Petitioner specified the following grounds for appeal, making it clear her intent to pursue her appeal:

1. Violation of 42 C.F.R. 431.243, which prohibits the State from dismissing a fair hearing appeal except where the appellant requests dismissal or fails to appear at a scheduled hearing.
2. Failure of the State to base hearing decisions exclusively on evidence introduced at an evidentiary hearing.
3. Failure of the State to issue a final determination within 90 days from the date of participants’ requests for fair hearings.
4. Failure to provide with reasonable promptness medically necessary equipment, including a speech device, supplies and services in the amount, duration and scope needed.
5. Violation of the reasonable promptness mandate of the Medicaid Act.
6. Violation of the Americans with Disabilities Act and the Rehabilitation Act of 1973.
7. Violation of the South Carolina Administrative Procedures Act by failing to promulgate regulations for the operation of Home and Community Based Waiver programs.
8. Illegal reduction of hours while Petitioner’s 2007 fair hearing appeal was pending.
9. Conscious indifference to Petitioner’s medical and psychological needs which has placed Petitioner at risk of harm.
10. Violation of Petitioner’s due process rights by requiring her to attend any hearings in Columbia, 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. R.p. 152. Petitioner also incorporated into this 2013 fair hearing appeal all allegations contained

in her 2007 appeal. R.p. 152. Petitioner also complained that DHHS violated her due process rights by reducing her hours during the administrative appeal, in violation of its own policies, failing to pay her mother the amounts ordered by the hearing officer and failing to comply with the order of the hearing officer. R.p. 153. She also requested an independent medical assessment.

Not satisfied with Petitioner’s Response, instead of ordering the requested medical

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<sup>1</sup> In November, 2014, DHHS informed the ALC that Petitioner’s claim was miscoded so that the reason the denial did not relate to the medical necessity of the device. R.p. 302-305.

assessment, as required by 42 C.F.R. 431.240 and SMM § 2902.8 (if medical necessity was at issue), and without scheduling a hearing, the hearing officer shifted the burden of providing written proof of medical necessity for the oximeter cable from DHHS to the Petitioner. R.p. 151. On April 4, 2013, the DHHS hearing officer dismissed Petitioner's appeal on the grounds of "abandonment." R.p. 147. The director of the DHHS Office of Appeals and Hearings, Robert French, advised Petitioner in a cover letter that any appeal of that order must be filed within 30 days with the South Carolina ALC. R.p. 162. Petitioner filed a notice of appeal in ALC on November 11, 2013 and an initial brief. R. 168-219. Respondent filed a Motion to Dismiss on September 11, 2013. R.p. 67.

On October 11, 2013, more than 240 days after Petitioner requested a fair hearing, the ALC issued a final state administrative order dismissing Petitioner's appeal based on abandonment. *Brook Waddle v. South Carolina Department of Health and Human Services*, Docket No. 13-ALJ-08-0267-AP, October 11, 2013. R.p. 2.

**DHHS Order in 2007 Appeal.** On November 19, 2013, DHHS Hearing Officer, Elizabeth Hutto (now Deputy Director of DHHS) issued an order in the 2007 appeal requiring DHHS to provide the hours her physician ordered. R.p. 19-20. That order acknowledges that Respondent's notice "did not include any reference to a supporting statute or regulation," did not inform Petitioner of her right to continuation of benefits during an appeal, and that it was sent to the wrong address. R. 20. The notice stated that the reason for the denial was her treating physician's order exceeded agency service limits, but the director of the HASCI program testified that there were no caps on services in the waiver document at that time. Id.

On March 29, 2007, Petitioner's physician ordered 84 hours per week of LPN services, 24 hours of RN services and attendant care at all times when a nurse was not present. R.p. 20.

DDSN sent a notice stating that HASCI services “cannot be offered when it can reasonable be expected that the cost of services ... would exceed the cost of a nursing facility level of care.” Id. The order acknowledges that “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.” R.p. 20-21. A DHHS official testified, however, that there were not cost caps applied to individuals and the director of the HASCI program testified that it would be improper for a denial to be based upon the individual’s services costing more than a nursing home “since there are no individual limits.” R.p. 21. Again, the notice made no mention of continued benefits pending the appeal and like the previous notice, it was sent to Petitioner’s home in Landrum, although Respondent knew she was hospitalized in Charleston. Id. Respondent’s witnesses presented conflicting testimony regarding the limits within the HASCI program. R.p. 21.

Petitioner requested a fair hearing on April 28, 2007. Id. The hearing officer found that while her appeal was pending, in July, 2008, her hours were reduced without notice. R.p. 22. Petitioner was still not receiving the RN services her physician ordered. Id. Respondent again reduced her hours in July, 2009 and, again failed to provide the required notice. R.p. 22-23. In 2010, Respondent limited Petitioner to receiving no more than 10 hours a day of nursing and attendant care (combined). R.p. 23. (There was testimony that previously, there was a 12 hour a day limit.) The hearing officer found that “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.” Id.

During the 2009 hearing, Petitioner’s physician testified by affidavit that she required 28 hours a week of RN services, 84 hours a week of LPN services and attendant care when a nurse

is not present. R.p. 27. At the 2012 hearing Petitioner's LPN testified as to her condition and medical needs. R.p. 27-29. The hearing officer wrote that Petitioner must be suctioned throughout the day, as a "mucus plug in her tracheostomy tube could be deadly without a nurse or the Petitioner's mother there to suction." R.p. 27. Her trach must be cleaned frequently, a task that can only be performed by a nurse or her mother. R.p. 27-28. The hearing officer found that Petitioner cannot be left alone and that she has serious medical complications, including grand mal seizures. R.p. 28.

The hearing officer determined that a centralized nurse at DDSN, who never met Petitioner, determines the Petitioner's needs for services and hours. R.p. 29-30. The order states that, according to the director of the HASCI program, if a treating physician orders more hours than allowed by the HASCI waiver limits, "the SCDDSN centralized nurse would not give any deference to that medical order" and would "not consider it." R.p. 30.

The hearing officer found that more than five years after Petitioner filed her appeal, Respondent "has not presented any medical witness with direct knowledge of the Petitioner's condition at either of the two hearings in this matter." R.p. 30. The medical director of DHHS, who the hearing officer reported had never met Petitioner and had no training in the treatment of head and spinal cord injuries was only "somewhat" familiar with Petitioner's case, but he could not recall any details related to her care. R.p. 30. The hearing officer found that he "did not have the expertise to override the orders of a treating physician." R.p. 30. His decision was based solely upon "Department guidance and the SCDHHS provider manual policy." R.p. 30. The centralized nurse noted "numerous medical conditions and complications that afflict the Petitioner" which are described at R.p. 31-32. According to the hearing officer, it appeared that Petitioner's condition worsened over the past year. Id. 32-33.

The LPN who treated Petitioner testified that except for her mother, there is little substitute coverage available, Petitioner was suffering from depression and had become withdrawn. R.p. 33. If Petitioner's mother became ill, there would be no one to provide for her care at home. R.p. 34. Through an affidavit, Petitioner testified that she wanted to remain at home and that she would "rather die than go to a SCDDSN Regional Center like Whitten Center or to attend a workshop..." R.p. 34.

The hearing officer found that community based treatment is appropriate for Petitioner and that she seeks to continue to receive care outside of an institution. R.p. 34. The order found that the denial notices were defective, and the reasons given for the denials were erroneous, according to the testimony of Respondent's witnesses. R.p. 35. The hearing officer found that Petitioner's hours were "improperly reduced several times" during the appeal "without notice and the opportunity to appeal." R.p. 35. During the appeal, Petitioner's father moved out of the home and her mother has been the sole family member providing care. R.p. 35. The hearing officer found that when her father moved out "Respondent should have conducted a new assessment of the Petitioner's needs when her family support was reduced to one person." R.p. 36. The order also found that Petitioner relied upon Respondent's erroneous assertion that she could not receive more than 2 hours a day of RN services. R.p. 36.

The hearing officer reported that DDSN and DHHS do not seek the recommendation of the treating physician regarding the need for nursing hours and that, more than five years after Petitioner requested a fair hearing, **Respondent had failed to "provide any records indicating that a physician for the Respondent ever reviewed Petitioner's medical needs."** R.p. 36-37.

Hearing Officer Hutto concluded that:

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.

R.p. 37. Ms. Hutto also ruled that “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. R.p. 38. The order provides that “The Petitioner’s benefits should have continued at the levels ordered by her treating physicians during the pendency of this appeal.” R.p. 38. The hearing officer’s findings regarding the State’s fundamental alteration defense under the Americans with Disabilities Act has subsequently been reversed by the South Carolina Court of Appeals in *Stogsdill v. DHHS*, 410 S.C. 273, 763 S.E.2d 638 (S.C. Ct. Ap. 2014). The hearing officer concluded at R.p. 42-43 that the hours ordered by her physician “should have continued throughout this matter.” **The order found that Respondent “violated the Petitioner’s due process rights in enforcing its waiver reductions against her during the pending appeal.”**

R.p. 43. Ms. Hutto concluded that “Respondent’s Medical Director showed a lack of first-hand knowledge of the Petitioner’s medical needs” and that it appeared that Respondent had not provided any medical examination of her needs after discharge from the hospital. R.p. 43-44.

The hearing officer concluded that “Due to the complicated medical needs and fragile condition of this Petitioner, it appears as though her medical needs could exceed Waiver limits.”

R.p. 44. **However, importantly, this hearing officer who is now a Deputy Director of DHHS ruled that “an Administrative Hearing Officer does not have the authority to exceed the limits of the Waiver program.”** R.p. 44. What better evidence might a waiver participant present to this Court of the futility of the state administrative process? Yet, DHHS has argued, and continues to argue in the federal courts that waiver participants’ sole remedy lies in the “fair hearing” process. But, this order demonstrates that such a remedy does not exist. The hearing officer ruled that “Should the Petitioner experience a change in circumstances, including a worsening of her condition, she can seek additional services beyond the waiver limits.” R.p. 44.

Yet, when Petitioner attempted to do just that in 2013, DHHS dismissed her fair hearing appeal without providing an evidentiary hearing.

The hearing officer found that Petitioner's mother was erroneously informed that DDSN rules prohibited her from receiving compensation for care she provided to her adult daughter and DHHS was ordered to pay \$140,148.60 for care she provided through the third quarter of 2013. R.p. 52.. R.p. 44. The order directed DHHS to pay for ongoing care at the rate paid to personal care attendants, because the parent of an adult child has no legal obligation to provide care. R.p. 44-47. But not one penny has been paid for these services more than seventeen months after that order was issued. R.p. 45. DHHS was ordered to pay for a speech device that had been ordered by Petitioner's physicians and promised to her by DHHS prior to discharge from the hospital. R.p. 49. (This payment was belatedly made.) It provides that Petitioner may seek an assessment for a new speech device and confirmed Petitioner's right to appeal any denial of a new speech device. But, the device had not been provided when DHHS and the ALC dismissed her 2013 appeal. R.p. 51. The order states that Petitioner "shall receive RN, LPN and Attendant Care Services to the extent allowable under HASCI Waiver limits." R.p. 51.

In the appeal to the ALC, Respondent attempted to derail Petitioner's appeal by arguing that Petitioner should have filed a motion to reconsider the dismissal, although the director of the Office of Hearings and Appeals instructed Petitioner that any appeal must be filed with the ALC within 30 days. R.p. 162. Petitioner argued that the hearing officer did not have the authority to dismiss her appeal in both her initial brief to the ALC, as well as her reply brief. R.p. 75, 92, 93-96, 135, 137. The ALC upheld the dismissal solely on the grounds of abandonment, based on the hearing officer's reliance on an agency regulation, without consideration of federal law that clearly preempts dismissal. R.p. 11. 42 C.F.R. 431.233.

## ARGUMENTS

**1. Did the South Carolina Court of Appeals err in determining that Petitioner's claim is moot?**

Without explanation, the South Carolina Court of Appeals upheld the decision of the ALC on the grounds of mootness. R.p. 483. The hearing officer did not dismiss the appeal on the grounds of mootness, nor did the ALC dismiss on those grounds. Both of those Executive Branch tribunals dismissed the appeal on the grounds of abandonment, relying solely upon a state agency regulation they argue gives hearing officers the right to dismiss an appeal when a hearing officer determines the claim has been abandoned, without regard to federal law. The South Carolina Court of Appeals issued an order on January 16, 2015 denying Respondent's motion to dismiss on the grounds of mootness. R.p. 402. Respondent did not file a motion to reconsider that order.

This claim of mootness appears to have been first raised in Respondent's brief to the Court of Appeals - that issue was not addressed in the ALC order. Evidence of mootness is not contained in the Record on Appeal filed by DHHS. Petitioner addressed Respondent's arguments in her reply brief to the Court of Appeals, and again in her Rule 59(e) motion. R.p. 472-475, 485-487. The lower court erred because Brook's claims for violation of the reasonable promptness and amount, duration and scope mandates of the Medicaid Act are not moot, but they are continuing, as are her claims for violation of the Americans with Disabilities Act. It was legal error to allow Respondents to define the issue in this case as being limited to the provision of an oximeter cable and for the agency and the lower courts to simply ignore the other issues Petitioner raised in this appeal. R.p 152-154. Nothing in the record supports such a narrow reading of Petitioner's claims, which were set forth in her January 30, 2013 appeal at R. 159, and supplemented in Petitioner's response dated March 19, 2013 identified as "Appellant's Response

to Order” at R.p. 152.<sup>2</sup>

This Court has held that “...a moot case exists where 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. Friends of Hunley, Inc.*, 630 S.E.2d 474, 477, 369 S.C. 20 (2006). A ruling in Petitioner’s favor that DHHS is in violation of the reasonable promptness, amount, duration and scope mandate and the Americans with Disabilities Act is what is needed to allow her to remain out of an institution or hospital. Her case is not moot because the issues she raised are “capable of repetition, but [have been] evading review.” *Sloan v. Greenville County*, 356 S.C. 531, 554, 590 S.E.2d 338 (S.C. App., 2003). See also *Byrd v. Irmo High Sch.*, 321 S.C. 426, 430, 431-432, 468 S.E.2d 861, 864 (1996). South Carolina has adopted a lenient approach to mootness, and a Petitioner must only show that the issue raised is capable of repetition, but she is not required to prove there is a “reasonable expectation” the issue will arise again. Citing *Byrd*, 321 S.C. at 431-32, 468 S.E.2d at 864.

The record here demonstrates that the violations of the Medicaid Act and the Americans with Disabilities Act are recurring and they continue to this very day. They are capable of repetition, yet they have evaded review. The United States Supreme Court has ruled that where a defendant's voluntary conduct is the basis for the potential mootness, it is “well settled” that the

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<sup>2</sup> Respondent has continued to fail to provide services and medically necessary equipment, but, because an evidentiary hearing was not provided, the evidence of those violations is not in the record through no fault of Petitioner. It is undeniable that the State continues to shamelessly issue final administrative determinations within 90 days, as is apparent by the failure to issue a final administrative order in Petitioner’s 2007 appeal, despite two remands by the ALC. Petitioner’s attempt to obtain relief through an administrative appeal has twice failed to provide needed services and equipment, or to require DHHS to comply with the federal standard of promptness. In *Peter Brown v. DHHS*, the Court of Appeals ruled that “The jurisdiction of any tribunal is determined by the allegations, not by the answer to the questions raised by the allegations.” 393 S.C. 11, 709 S.E.2d 701, 704 (S.C. App. 2011). Likewise, the issues on appeal here are controlled by the Petitioner’s allegations, not DHHS’ answer to those allegations.

voluntary cessation of the challenged practice does not deprive the 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 Env'tl. Servs. (TOC), Inc.*, 528 U.S. 167, 189, 120 S.Ct. 693, 145 L.Ed.2d 610 (2000). In *Doe v. Kidd I*, the Fourth Circuit held that the Medicaid participant’s claim against DHHS was not moot where DHHS provided some services to Doe, but not the services she was entitled to receive. 501 F.3d 348, 354 (4th Cir. 2007). On the second appeal to the Fourth Circuit, four years later, that court found that the State defendants admitted “that they abdicated their responsibility to furnish Doe with the necessary services in the least restrictive environment.” *Doe v. Kidd II*, 419 F.Appx. 411 (4th Cir. 2011).

More recently, the Fourth Circuit recognized in a case alleging violation of the Medicaid Act and the Americans with Disabilities Act that “mootness does not result from a defendant's voluntary cessation of his allegedly illegal conduct unless it is clear that the behavior is unlikely to recur.” *Pashby v. Delia*, 709 F.3d 307, 316 (4th Cir. 2013). In *Pashby*, the court held that dismissal of the waiver participants’ administrative claims did not moot their claims for violation of the Americans with Disabilities Act and the Medicaid Act. *Id.* at 316. The Court of Appeals ruling conflicts with these decisions and decisions of the United States Supreme Court regarding mootness. *Friends of the Earth*, *supra*, and *City of Mesquite v. Aladdin's Castle, Inc.*, 455 U.S. 283, 289 & n. 10, 102 S.Ct. 1070, 71 L.Ed.2d 152 (1982).

DHHS still has not provided the services ordered by the hearing officer in 2013, which her treating physicians and its own hearing officer determined to be medically necessary. Despite the Court of Appeals ruling that the caps imposed in 2010 violate the Americans with Disabilities Act in *Stogsdill v. DHHS*, DHHS continues to apply those caps to Petitioner and all other waiver

participants who have not filed a lawsuit in federal court. 410 S.C. 273, 763 S.E.2d 638 (S.C. Ct. Ap. 2014). This Court may take judicial notice that DHHS has not amended its waiver document to comply with that state court ruling. The failure to provide services with reasonable promptness based on physicians' orders and to pay Petitioner's mother, as ordered by the hearing officer in 2013, are continuing violations that have prejudiced Petitioner.

The lower court erred in its determination that providing a oximeter cable caused Petitioner's claims for violation of her due process rights to be moot. If this error is not corrected, DHHS will have every incentive to burden waiver participants and the courts with administrative appeals, only to provide services after years of appeals in order to moot those claims, jeopardizing waiver participants ability to remain in their homes.

**2. Violation of Petitioner's right to due process.**

As a condition of receipt of federal funding for Medicaid services, the State must maintain a hearing system that meets the due process standards set forth in *Goldberg v. Kelly*, as well as regulations interpreting 42 U.S.C. 1396a(a)(3). 397 U.S. 254, 267-68, 90 S. Ct. 1011 1020, 25 L.Ed.2d 287 (1970). 42 C.F.R. § 431.205(d). "The fundamental requisite of due process of law is the opportunity to be heard." *Goldberg*, 397 U.S. at 267, quoting *Grannis v. Ordean*, 234 U.S. 385, 394, 34 S.Ct. 779, 783, 58 L.Ed. 1363 (1914). The hearing must be provided "at a meaningful time and in a meaningful manner." *Armstrong v. Manzo*, 380 U.S. 545, 552, 85 S.Ct. 1187 1191, 14 L.Ed.2d 62 (1965). More than three years have passed, and Petitioner still has not been provided with an evidentiary hearing on the claims made in 2013.

Federal regulations interpreting 42 U.S.C. 1396a(a)(3) require DHHS to provide Medicaid participants timely and adequate notice that details the reasons for the proposed action or failure to provide services promptly, and an effective opportunity to defend by confronting any

adverse witnesses and by presenting her own arguments and evidence orally. 42 C.F.R. 431.200 et. seq. On top of the constitutional requirements for administrative hearings outlined in *Goldberg*, 397 U.S. 254, and its progeny, federal regulation 42 C.F.R. § 431.205 prescribes even greater procedural safeguards that required in other government benefits cases. 42 C.F.R. § 431.205(d) specifically requires the hearing system to satisfy any additional standards specified by the federal regulations. *Featherston v. Stanton*, 626 F.2d 591, 593 (7th Cir. 1980). The requirements for "Fair Hearings for Applicants and Beneficiaries" are outlined at 42 C.F.R §§ 431.200 to 431.250.

**A. Have Petitioner's due process rights been violated by the State's failure to provide notices containing all information required by 42 C.F.R. 431.210?**

*Goldberg* further dictates the judgment must rest solely upon the legal rules and evidence adduced at a hearing and states "where governmental action seriously injures an individual, and the reasonableness of the action depends on fact findings, the evidence used to prove the Government's case must be disclosed to the individual so that he has an opportunity to show that it is untrue." *Id.* at 270-71. The federal regulations at 42 C.F.R. 431.210 require the agency to provide written notices that inform the participant of the reasons for the intended action, the specific regulations that support the action, and an explanation of the recipient's right to request an administrative hearing. On January 9, 2013 DHHS informed Petitioner that the reason for denying payment for a medically necessary device was "Provider submitted no clinical information supporting request and prescription when asked to do so." R.p. 160. That was not true - and it took DHHS more than two years to provide a totally different "reason." It is undisputed that this notice did not contain the statute or regulations DHHS relied upon to deny the device, another violation of 42 C.F.R. 431.210.

In November, 2014, after the Record was closed, Respondent filed an affidavit with the

ALC (attached to the State's motion to dismiss) that constitutes proof that the denial was in no way related to the medical necessity for the device.<sup>3</sup> R.p. 304. This affidavit shows that the real reason for the denial was totally different. Respondent informed the court that the reason DHHS denied payment for the device was that the provider used the wrong code on the certificate of medical necessity. R.p. 304-305. "Upon researching the issue" - nearly two years after Petitioner's request for the device was denied - the DHHS official in charge of requests for durable medical equipment informed the tribunal that had the proper code been used, the device would have been provided without prior authorization. R.p. 300-304. But, Petitioner was denied the opportunity to present evidence to contradict this "reason" or to cross examine DHHS' witnesses to determine the truthfulness of this new justification for denying Petitioner a device needed to determine whether she needs to have more oxygen administered.

Without explaining the factual basis for its decision, the Court of Appeals determined that Brook's case was moot. R.p. 483. Had DHHS complied with federal regulations requiring an evidentiary hearing, the agency's error would have been discovered within 90 days of Petitioner's request for a fair hearing in 2013, the device should have been provided in 2013 and state resources expended in this saga that has already lasted more than three years would not have been wasted.

Since the Supreme Court's decision in *Goldberg*, courts have been consistent in requiring that notices of denials or changes in welfare benefits must be clear and specific. As *Goldberg* pronounced, due process requires that the reason for its action be stated in the notice in sufficient detail to allow the affected individual "an effective opportunity to defend by confronting any

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In *Featherston v. Stanton*, the Seventh Circuit found that the "congressional plan" is for review panels making Medicaid decisions act as adjudicators, not as advocates or adversaries. 626 F.2d 591, 594 (7<sup>th</sup> Cir. 1980). But, throughout this case, DHHS and its counsel have acted as adversaries, disregarding the injuries inflicted.

adverse witnesses and by presenting his own arguments and evidence orally." *Id.* at 267-68; see *Featherston*, 626 F.2d 591; *Vargas v. Trainor*, 508 F.2d 485 (7th Cir. 1974); *Tripp*, 640 F. Supp. at 857. Petitioner had no way of knowing that the reason for the denial was that the wrong code was used, because that reason was not included in the notice provided by Respondent. The hearing officer even required Petitioner - a quadriplegic patient struggling to breathe and meet the day to day demands of living - provide evidence of medical necessity, in writing, before a hearing would be scheduled. R.p. 151. She ignored Petitioner's request for an independent medical assessment, to be provided at the expense of the State. This was a clear violation the State Medicaid Manual requirement at SMM § 2902.8 a section titled "Claimant's Right to a Different Medical Assessment."<sup>4</sup> This section interprets 42 CFR § 431.240(b) as follows:

An appeal on medical issues may involve a challenge to the Medical Review Team's decision regarding disability; or there may be disagreement about the content of reports concerning the appellant's physical or mental condition or the individual's need for medical care requiring prior authorization. When the assessment by a medical authority, other than the one involved in the decision under question, is requested by the claimant and considered necessary by the hearing officer, obtain it at agency expense. The medical source should be one satisfactory to the claimant. The assessment by such medical authority shall be given in writing or by personal testimony as an expert witness and shall be incorporated into the record.

These due process rights to notice are especially important where, as here, benefit recipients challenge government action as resting on incorrect or misleading factual premises or on misapplication of rules or policies to the facts of particular cases. *Goldberg*, 397 U.S. at 268. As it turned out, medical necessity was never the reason for the denial, thus the information the

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<sup>4</sup> The Supreme Court of Connecticut recognized that: "The State Medicaid Manual is the 'official medium by which [CMS] issues mandatory, advisory, and optional [m]edicaid policies and procedures to the [m]edicaid [s]tate agencies....' *S.D. ex rel. Dickson v. Hood*, supra, 391 F.3d at 590, quoting State Medicaid Manual, supra, Foreword. The State Medicaid Manual is 'relatively informal,' but is 'entitled to respectful consideration in light of the agency's significant expertise, the technical complexity of the [m]edicaid program, and the exceptionally broad authority conferred upon the Secretary under the [a]ct.' *S.D. ex rel. Dickson v. Hood*, supra, at 590 n. 6; accord *Rabin v. Wilson-Coker*, 362 F.3d 190, 197-98 (2d Cir.2004) (statutory interpretation in manual entitled to 'significant,' but not conclusive, deference because it is not subject to notice and comment process)." *Semerzakis v. Commissioner of Social Services*, 873 A.2d 911, 274 Conn. 1, fn 9 (Conn. 2005).

hearing officer demanded before proceeding was irrelevant to the appeal. As in *M.A. v. Norwood*:

“Without effective notice, a claimant's due process right to a fair hearing is rendered

fundamentally illusory.” Case No. 15-3116 (N.D.Ill. 2015). As the Second Circuit ruled:

In order to be constitutionally adequate, notice of benefits determinations must provide claimants with enough information to understand the reasons for the agency's action. See *Goldberg*, 397 U.S. at 267-68, 90 S.Ct. 1011; see also *Escalera v. New York City Hous. Auth.*, 425 F.2d 853, 862 (2d Cir.1970). This requirement, like the right to a fair hearing, is a basic requirement of procedural due process. Claimants cannot know whether a challenge to an agency's action is warranted, much less formulate an effective challenge, if they are not provided with sufficient information to understand the basis for the agency's action. See, e.g., *Vargas v. Trainor*, 508 F.2d 485, 490 (7th Cir.1974). Thus, in the absence of effective notice, the other due process rights afforded a benefits claimant “such as the right to a timely hearing” are rendered fundamentally hollow. See *Escalera*, 425 F.2d at 862 (noting that a hearing would be of little value if the defendant could deny the claimants benefits based on reasons of which the claimants had no knowledge).

*Kapps v. Wing*, 404 F.3d 105, 123-124. (2nd Cir. 2005). Here, as in that case:

“The meek and submissive,” in contrast, will “remain in the dark. . . .” *Vargas*, 508 F.2d at 490. Such an outcome seems particularly likely where, as here, many HEAP claimants face obstacles, such as advanced age, or disability, which make the process of seeking further information difficult.

*Id.* at 126. The information contained in the notice was not sufficient to allow Petitioner to

“prepare an effective appeal” - and simply refusing to schedule a hearing does not remedy that continuing violation. *M.A. v. Norwood* at 10. This violation of Petitioner’s due process rights is subject to repetition and the orders of hearing officer Hutto demonstrate that DHHS has evaded review for many years. R.p. 38, 43, 55-56.

The plain language of subsection ( c) of 42 C.F.R. 431.210 also requires that the notice must contain “[t]he specific regulations that support, or the change in Federal or State law that requires, the action.” It is undisputed that the notice does not contain this information, which is also needed to mount an effective appeal. Instead, Petitioner was left to guess at the legal grounds Respondent relied upon - legal grounds which totally ignored controlling federal law.

Petitioner has suffered severe injury due to the failure of Respondent to provide services

even the DHHS hearing officer found her to be entitled to receive in 2012. She has wasted years and scarce resources in futile administrative appeals, while Respondent has ignored federal law and the ruling of the South Carolina Court of Appeals in *Stogsdill v. DHHS* with absolute impunity. Her family has suffered, jeopardizing her ability to remain at home. The lower court's decision should be reversed, because these violations are subject to repetition and they have evaded review.

**B. Were Petitioner's due process rights violated when the State dismissed her appeal over her objections without providing an evidentiary hearing?**

Federal law mandates that an evidentiary hearing must be provided to any Medicaid participant who requests an appeal when services are denied or not provided promptly. 42 U.S.C. 1396a(a)(3). Not only must Respondent provide an evidentiary hearing, but the agency's decision must be based "exclusively" on evidence presented at that hearing. 42 C.F.R. 431.244(a). It is impossible to base a decision "exclusively" on evidence presented at the evidentiary hearing when an appeal is dismissed without providing a hearing.

Federal constitutional due process requires the judgment to rest solely upon the evidence adduced at the administrative hearing. *Goldberg*, 397 U.S. at 270-71. Federal regulations at 42 C.F.R. 431.200 et. seq. "implement(s) section 1902(a)(3) of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly." 42 C.F.R. 431.200.

Providing a hearing system meeting the requirements of 42 C.F.R. 431.205-246 is mandatory, not optional for the states that participate in Medicaid. 42 C.F.R. 431.202. The State Medicaid Agency is responsible for maintaining a hearing system that meets not only the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), but also all additional standards specified in 42 C.F.R. 431.200-246. 42 C.F.R. 431.205. The State Medicaid Agency

must grant a hearing (1) to any applicant who requests it because his claim for services is denied or is *not acted upon with reasonable promptness*, and to (2) any beneficiary who requests it because he or she believes the agency has taken an action erroneously. (Emphasis added.) 42 C.F.R. 431.220. The State may not, as it did in this case, “limit or interfere with the applicant's or beneficiary's freedom to make a request for a hearing,” but it may “assist the applicant or beneficiary in submitting and processing his request. 42 C.F.R. 431.221(b) and ( c).

Federal law provides only two permissible grounds for denying or dismissing a fair hearing appeal, neither of which are present here. 42 C.F.R. 431.223. Federal regulations at 42 C.F.R. § 431.223 state that the "agency may deny or dismiss a request for a hearing only if (a) [t]he applicant or recipient withdraws the request in writing; or (b) [t]he applicant or recipient fails to appear at a scheduled hearing without good cause."

The State Medicaid Manual, which fleshes out this regulation, is entitled to deference. *Fishman v. Daines*, No. 09-cv-5248 (D.C.N.Y. March 4, 2016). The State Medicaid Manual is not produced by the State, but it is “an informal rule issued by the Department of Health and Human Services' . . . Centers for Medicare and Medicaid Services . . . ." *Wong v. Doar*, 571 F.3d 247, 250 (2d Cir. 2009). It provides at State Medicaid Manual § 2902.3(B) that a Medicaid fair hearing request may only be considered abandoned when:

...neither the claimant nor his representative appears at scheduled hearing, and if within a reasonable time (of not less than 10 days) after the mailing of an inquiry as to whether he wishes any further action on his request for a hearing no reply is received.

The hearing officer's ruling and ALC's affirmance, finding that Petitioner “abandoned”

her appeal based on a DHHS regulation allowing a hearing officer to dismiss an appeal, is preempted by the clear and unambiguous directives at U.S.C. 1396a(a)(3), 42 C.F.R. 431.223 and the State Medicaid Manual at § 2902.3(B). Because those rulings are contradicted by controlling federal law, they must be reversed to do justice in this case.

C. **Did the Court of Appeals err by striking information Petitioner incorporated by reference in identifying her issues on appeal, then determining Petitioner's case to be moot based on an affidavit presented by Respondent after her appeal was dismissed that was not included in the Record on Appeal prepared by DHHS?** Petitioner clearly incorporated allegations contained in the 2007 in her appeal filed in 2013. R.p. 152-153. She was entitled to rely upon her constitutional rights and federal statutes and regulations, which guaranteed she would have an opportunity to present her case without interference, to refute pertinent facts and circumstances, to examine the records relied upon Respondent, to present witnesses and to cross examine the State's witnesses.<sup>5</sup> Respondent should be estopped from preventing Petitioner from providing evidence related to the 2007 appeal, which Respondent was on notice to be at issue in this appeal. It is well established that "He who seeks equity must do equity, and, He who comes into equity must come with clean hands." *Hemingway v. Mention*, 228 S.C. 211, 89 S.E.2d 369 (1955). The Court of Appeals rulings are particularly egregious, because it relied upon information not contained in the record to reach its decision that Petitioners' claims are moot. As former Chief Justice Toal recently noted in the preface to her book on trial practice:

*Rules of practice and procedure are devised to promote the ends of justice, not to defeat them. A rigid and undeviating judicially declared practice under which courts of review would invariably and under all circumstances decline to consider all questions which had not previously been specifically urged would be out of harmony with this policy. Orderly rules of procedure do not require sacrifice of the rules of fundamental justice.*

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<sup>5</sup> 42 C.F.R. § 431.242, titled "Procedural rights of the applicant or beneficiary" provides that the appellant must be given an opportunity to—

- (a) Examine at a reasonable time before the date of the hearing and during the hearing:
  - (1) The content of the applicant's or beneficiary's case file; and
  - (2) All documents and records to be used by the State or local agency or the skilled nursing facility or nursing facility at the hearing;
- (b) Bring witnesses;
- © Establish all pertinent facts and circumstances;
- (d) Present an argument without undue interference; and
- (e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

Justice Hugo L. Black, *Hormel v. Helvering*, 312 U.S. 552 (1941), quoted in *Appellate Practice in South Carolina*, Third Edition, Jean Hoefer Toal et. al. (2016). The lower court's decision should be reversed and this Court should consider evidence related to the 2007 appeal, not only because it was incorporated by reference, but because it would be a travesty of justice and encouragement to this agency to win appeals by denying basic fundamental rights of disabled persons who rely upon those services.

**3. Has the State violated the Medicaid Act by failing to issue a final administrative order and to provide services with reasonable promptness, in the amount, duration and scope needed to prevent institutionalization and hospitalization, and are these violations capable of repetition, yet they have evaded review?**

The Medicaid statute requires that states electing to participate in Medicaid "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. 1396a(a)(8). *Doe v. Kidd I*, 501 F.3d 355. See also *Wilson v. Gordon*, Case No. 14-6191 at 2 (6th Cir. 2016). Regulations implementing the statute provide that "the determination of eligibility for any applicant may not exceed" 90 days for those "who apply for Medicaid on the basis of disability" and 45 days for all other applicants. 42 C.F.R. 435.912(c)(3). *Doe I* at 355 and *Wilson* at 2. 42 C.F.R. 431.244(f) also establishes a time frame for issuing a final state administrative decision. In *Shakhnes v. Berlin*, the Second Circuit interpreted that regulation, holding that the regulation establishes an enforceable right. 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.

Respondent argues that the word "ordinarily" means that it may take years where the

issues are complicated. This debate can be resolved by review of the State Medicaid Manual directive at SMM § 2902.10, which provides:

2902.10 Prompt, Definitive And Final Action (42 CFR 431.244(f).--The requirement for prompt, definitive, and final administrative action means that all requests for a hearing are to receive prompt attention and will be carried through all steps necessary to completion. The requirement is not met if the State dismisses such a request for any reason other than withdrawal or abandonment of the request by the claimant or as permitted elsewhere in these instructions. Adhere to the time limit of 90 days between the date of the request for the hearing and the date of the final administrative action except where the agency grants a delay at the appellant's request, or when required medical evidence necessary for the hearing can not be obtained within 90 days. In such case the hearing officer may, at his discretion, grant a delay up to 30 days.

Thus, "ordinarily" means that the State must issue definitive and final action within 120 days, if the appellant has requested an extension. The Fourth Circuit has ruled that the requirements of the reasonable promptness mandate are "clear" and therefore establish rights under the Medicaid Act. *Doe v. Kidd II* at 11. As Respondent recognized in that case, 42 C.F.R. 435.930 provides that Medicaid services must be made available "without any delay caused by the agency's administrative procedures." See also *Doe 1-13 By and Through Doe, Sr. 1-13 v. Chiles*, 136 F.3d 709, 721-22 (11th Cir. 1998) (upholding a district court's conclusion that "reasonable promptness" means a period not to exceed ninety days). In any event, failing to provide a hearing and final state administrative determination for years violates the reasonable promptness mandate. Petitioner is entitled to a ruling in her favor on her reasonable promptness claims. This is a matter of great public interest, as demonstrated by Respondents disregard for the federal statute and applicable regulations.

It is undisputed that Petitioner requires around-the-clock supervision due to the need for suctioning and monitoring of aspiration, which she would receive in a hospital or nursing home. The Medicaid Act requires that services (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual. 42 U.S.C. 1396a(a)(10)(B).

CMS has adopted a regulation interpreting this statute 42 C.F.R. 440.240. *Pashby v. Delia*, 709 F.3d 307, 340 (4th Cir. 2013). In *Stogsdill*, the Court of Appeals ruled that DHHS is prohibited from imposing caps on services where the participant, like Stogsdill and Petitioner is at risk of institutionalization. 763 S.E.2d 645. The Court should reverse the lower court's ruling and find that Petitioner has not been provided medically necessary services in the amount, duration, and scope necessary.

**4. Has the State violated the Americans with Disabilities Act through the continued application of binding norms not promulgated as regulations and failure to provide reasonable accommodations required by *Olmstead v. L.C.* and *Stogsdill v. DHHS* and are these violations ongoing?**

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 I*, 501 F.3d 348 (4<sup>th</sup> Cir. 2007), citing *Olmstead v. L.C.* 527 U.S. 581 (1999); S.C.Code Ann. § 44-20-20 (2006).

The issue of whether providing services in excess of the caps imposed by DHHS violates the integration mandate of the ADA has been resolved in *Stogsdill*, where the Court of Appeals ruled adopted the Fourth Circuit's ruling in *Pashby*, holding that "budgetary concerns do not alone sustain a fundamental alteration defense.... financial constraints alone cannot sustain a fundamental alteration defense." 709 F.3d at 323-24 (internal quotation marks omitted). The Court of appeals ruled that DHHS imposed caps for no other reason than "a general budgetary reduction and financial constraints" and that providing services waiver participants need to remain in their homes would not result in a fundamental alteration of the Waiver program.

DHHS has not promulgated regulations to assess the need for services and has argued for years that it is not required to do so. *Protection and Advocacy v. DHHS*, Appellate Case No. 2014-000244, Opinion No. 5383 (S.C. Ct. Ap. 2016). These issues are subject to repetition, yet they have evaded review for years. It is not necessary to remand this case for a determination of

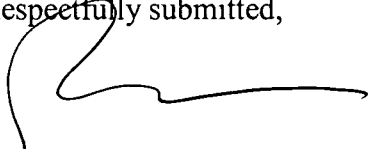
hours needed. Hearing officer Hutto, now a Deputy Director at DHHS ruled after two days of evidentiary hearings that Petitioner is “a quadriplegic, who relies upon a tracheostomy to breathe, and suffers from several complicated medical conditions including recurrent pneumonia; seizures, and skin break down. Due to her condition, she is at continued risk of infection. She requires constant care and cannot be left alone.” R.p. 37.

To remand this case would place Petitioner at risk of further deterioration in her extremely fragile condition. She has already endured three days of administrative hearings, nine years of living at home without the services the DHHS hearing officer ruled she is entitled to receive during the appeal. Hearing officer Hutto ruled that Petitioner should be provided the services that her physician ordered. R.p. 14-53 and 54-57. This Court should grant this Petition, because this is an issue of tremendous public importance, as DHHS still has not changed its policies or the waiver document to comply with the ruling in *Stogsdill*.

#### CONCLUSION

This Court should grant Petitioner’s Petition for a Writ of Certiorari because her appeal involves novel questions of law which affect thousands of the most vulnerable citizens of South Carolina and their families struggling to keep them at home. The due process claims raised in this Petition involve substantial constitutional issues and the lower courts’ rulings on federal questions contradict decisions of the federal courts of appeals and the United States Supreme Court. The failure to apply the ruling of the South Carolina Court of Appeals in *Stogsdill v. DHHS* to Petitioner’s pending appeals is inconceivable and the violations of the integration mandate of the ADA are continuing. For the reasons stated above, Petitioner respectfully prays that this Court will grant the Petition for a Writ of Certiorari.

Respectfully submitted,



Patricia Logan Harrison  
611 Holly Street  
Columbia, South Carolina 29205  
[pharrison@loganharrisonlaw.com](mailto:pharrison@loganharrisonlaw.com)  
803 360 5555

Kenneth C. Anthony, Jr.  
250 Magnolia Street  
Spartanburg, SC 29306  
(864) 582-2355

Attorneys for Petitioner

July 11, 2016.

RECEIVED

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SC SUPREME COURT

IN THE STATE OF SOUTH CAROLINA

In the Supreme Court

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS

Case No. 2013-002415

Brook Waddle, ..... Appellant,

v.

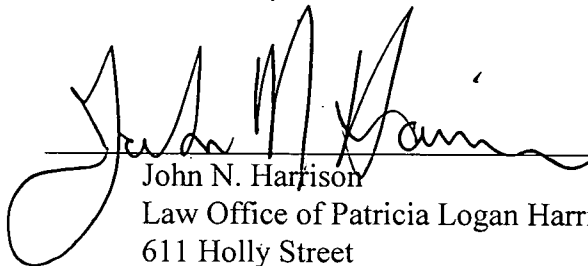
South Carolina Department of Health and Human Services, ..... Respondent.

CERTIFICATE OF SERVICE

John N. Harrison certifies that he has served the *Petition for a Writ of Certiorari* in the above captioned case by hand delivery to the following on July 11, 2016:

Damon C. Wlodarczyk, Esq.  
Riley Pope & Laney, LLC  
2838 Devine Street  
Columbia, SC 29205

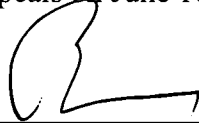
Shealy B. Reibold, Esq.  
SC Department of Health & Human Services  
1801 Main St.  
Columbia, SC 29201

  
\_\_\_\_\_  
John N. Harrison

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

**CERTIFICATE OF COUNSEL**

Counsel for petitioner hereby certifies that the Petition for Rehearing was made and finally ruled on by the Court of Appeals on June 10, 2016.



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Patricia Logan Harrison  
611 Holly Street  
Columbia, South Carolina 29205