STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Carolyn C. Matthews, Administrative Law Judge

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

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent

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BRIEF OF RESPONDENT

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Is there Substantial Evidence in the Record to uphold and does the law support the Hearing Officer's and the Administrative Law Judge's (ALJ's) decisions that:

1) the risk of institutionalization raised by the Appellant was speculative and the actions of the Respondent were not violative of the Americans with Disabilities Act (ADA);
2) in authorizing the Appellant's services, appropriate weight was given to the information submitted by the Appellant's attending physician;
3) providing the Appellant services in the amount that he wants would be a fundamental alteration of the nature of the Respondent's program;
4) the 2010 reductions were lawful and not violative of the South Carolina Administrative Procedures Act;
5) the Appellant was afforded adequate due process;
6) the DHHS provided services with reasonable promptness, it is the adequacy of those services that is in dispute; and
7) the Respondent did not violate the comparability requirements of the Medicaid Act?

STATEMENT OF THE CASE

General Background:

The Appellant in this matter is a Medicaid-eligible individual, who has been receiving services under the South Carolina Mental Retardation/Related Disabilities (MR/RD) waiver. Under this waiver, beneficiaries can be provided a mix of services through the Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which, by having certain generic requirements of the Medicaid program "waived," States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. This and other waivers operated by DDSN are for home and community based services under Section 1915(c) of the Social Security Act [42 USC §1396n(c)]. These types of waivers allow services to be provided in the home or community, in lieu of institutional services. On January 1, 2010, the five-year renewal of the MR/RD waiver, as approved by the Centers for Medicare and Medicaid Services (CMS), went into effect. The renewed waiver included a cap or limit on some services and excluded others. The current waiver documents including the waiver and the approvals by the CMS are at http://www1.scdhhs.gov/openpublic/insideDHHS/Bureaus/BureauofLongTermCareServices/Mental%20RetardationRelated%20Disability%20Waiver.asp

The SCDDSN is responsible for the day-to-day operation of this waiver. The Department of Health and Human Services (Department, DHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the waiver. This appeal is directly from an Administrative Law Court Order sustaining the Decision of the SCDHHS Appeals Division upholding SCDDSN's action reducing services to the Appellant. The reduction was the result of the

limitations set forth in the renewed waiver.

When he was under twenty one years of age, the Appellant was likely receiving school-based services in addition to waiver services. The Appellant "lost" his school services, probably under the Individuals with Disabilities Education Act (IDEA) because he turned twenty one, not because of anything the Departments did. Since he became an adult, according to the programs and prior to the January, 2010, waiver changes, the Appellant was receiving a combined 69 hours of Personal Care Aide and Companion Care services per week and about 36 hours of Respite Care per week. Personal Care Aide II (referred to now as PC2 in the waiver document, page 47 of 174) services consist of hands-on personal care that a person needs to accomplish their activities of daily living such as bathing, toileting, dressing and eating. Adult Companion Services are similar to PC2 services but include an aspect of community integration. Waiver document, page 64 of 174. Respite Care can be a range of services, including personal care but is designed to provide services when the normal caregiver is absent or needs relief. Waiver document, page 50 of 174 and R. p. 335.

The new waiver capped any combination of PC2 and Adult Companion services at 28 hours per week. The normal cap for Respite Services under the new waiver is 68 hours per month (or almost 16 hours per week), but exceptions can be granted for up to 240 hours per month (or about 56 hours per week). Under these new limits, the Appellant's services were to be reduced to 28 hours of PC2-type services (including Adult Companion services) per week and 68 monthly hours of Respite Care. Also, in this case,

in accordance with the new waiver, the Appellant's Occupational, Physical and Speech Therapies were to be discontinued.

In apparent anticipation of the reduction in services, on December 30, 2009, the Appellant sought a Reconsideration of the DDSN's proposed reductions, however, the Reconsideration was denied (R. p. 940). The Reconsideration was conducted by Dr. Beverly A.H. Buscemi, the Director of the DDSN who found that she was "...not at liberty to exceed the established limits." R. p. 940.

The Appellant appealed all of the waiver reductions and elimination of services to the DHHS Appeals Division on the grounds of due process, reasonable standards, prompt provision of service, the Americans with Disabilities Act as interpreted by Olmstead v. L.C., 527 U.S. 581 (1999), and improper use of federal stimulus funds. Notice of Appeal (R. pp. 933-939). In his Decision of September 14, 2010 the Department's Hearing Officer sustained the Departments' actions. The Hearing Officer concluded:

1. that the waiver was lawful;
2. that the Appellant had actual notice of the DDSN's proposed actions;
3. That the Olmstead integration mandate was not violated;
4. That the discussions leading up to the waiver changes, the various audits and funding of the DDSN and the stimulus funds were not relevant to the issue;
5. That the previous case had ended; and
6. That States had experienced budget reductions, so the stated purpose of the reductions seemed reasonable.

The Department's Final Administrative Decision (R. pp. 16-26).

On or about October 20, 2010, the Appellant appealed to the Administrative Law Court, alleging:

1. Due process, reasonable standards, and reasonable promptness flaws in the Departments' processes;
2. Violations of the Medicaid requirements to make sufficient payments to providers, to provide comparable services among similar beneficiaries, and to provide services irrespective to diagnosis and condition;
3. Violations of the American Recovery and Reinvestment Act (stimulus funds);
4. Failure to prove feasible alternatives;
5. Violations of the Americans with Disabilities Act, as explicated by the Olmstead decision; and
6. Failure to defer to the Appellant's treating physicians.

Notice of Appeal (R. pp. 933-937).

The ALC upheld the DHHS Appeals Division on March 13, 2013, essentially agreeing with the Hearing Officer. ALC Decision dated March 13, 2013, R. pp. 5-15. This appeal followed. Notice of Appeal, April 9, 2013, R. pp. 933-937.

The Appellant's position is that his previous case, [R. S.] v. SCDHHS, 09-MISC-017, was the start of this dispute, and this case is just a continuation of that case. We disagree as we believe there is nothing in the previous Decision in 09-MISC-017 to indicate that

the Hearing Officer retained jurisdiction for further review. We believe that upon remand to the DDSN, the Appellant's case was reevaluated and reauthorized by the local board. Then, the new waiver required all services to be reevaluated, taking into consideration the new limits. This case is about the reduction in services to the Petitioner occasioned by the new January 1, 2010, wavier limits.

On or about January 18, 2010, after the initial cuts, but prior to the appeal, the Appellant's Service Coordinator applied for an increase in respite care. On March 1, 2010, the local DSN Board increased respite care hours to 104 hours per month for a total of 172 hours of respite care per month (or about 40 hours per week). See, R. pp. 158-168 and the descriptions of services cited above.[1]

Nature of the Action

Thus, this is a matter before the Court of Appeals as an Appeal from an Order of the Administrative Law Court, issued on March 13, 2013. As recently articulated by the Appellate Courts:

> This court's scope of review is set forth in section 1–23–610(B) of the South Carolina Code (Supp.2009). That section provides:
>
> The review of the administrative law judge's order must be confined to the record. The court may not substitute its judgment for the judgment of the administrative law judge as to the weight of the evidence on questions of fact. The court of appeals may affirm the decision or remand the case for further proceedings; or it may reverse or modify the decision if the substantive rights of the petitioner have been prejudiced because the finding, conclusion, or decision is:
> (a) in violation of constitutional or statutory provisions;
> (b) in excess of the statutory authority of the agency;
> (c) made upon unlawful procedure;
> (d) affected by other error of law;

[1] In June of 2012, due to a parent's illness, respite services were increased to 240 hours per month.

(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.

Doe v. South Carolina Dept. of Health and Human Services 398 S.C. 62, 727 S.E.2d 605, (S.C.,2011) and ESA Services, LLC v. South Carolina Dept. of Revenue, 392 S.C. 11, 19, 707 S.E.2d 431, 436 (Ct..App.2011)

ARGUMENT

1) The risk of institutionalization raised by the Appellant was speculative and the actions of the Respondent were not violative of the Americans with Disabilities Act;

The Appellant would have the Court equate any risk of institutionalization to a serious and imminent risk. In fact, most courts that have addressed the issue have found that:

> under Olmstead and the applicable ADA regulations, when treatment professionals have determined that community placement is appropriate for disabled individuals, those individuals do not oppose the placement, and the provision of services would not constitute a 'fundamental alteration,' states are required to place those individuals in community settings rather than institutions.... The Plaintiff may succeed on his ADA claim if the Defendant's action places him at a "high risk" of premature entry into institutional isolation.

Royal ex rel. Royal v. Cook 2012 WL 2326115, 8 (N.D.Ga.) (N.D.Ga.,2012). See also Fisher v. Oklahoma Health Care Authority, 335 F.3d 1175, 1181 (10th Cir.2003)

For the disabled then, States must meet the heightened standard that a limitation in services must not violate the integration mandate as articulated in Olmstead. In this case we believe that means that the limitation in services cannot put the Appellant in high or

serious jeopardy of institutionalization, unless to avoid doing so, the State has to fundamentally alter its program.

Assuming that the decision in Olmstead, extends to persons at serious risk of institutionalization, there is not enough in this case to indicate that serious and imminent possibility for the Appellant.

In this case, although it has certainly been a hardship on his family as it would be on any family, the Appellant has been maintained in the community. Additional respite services have been added. The Appellant has support equipment including a motorized wheelchair (R. p. 305, line 4), a Hoyer lift and a Surehands lift (R. p. 325, line 25 & p. 326, line 2), a special door on his apartment and a special van (R. p. 326, lines 4 & 5, p. 326, line 7), and a phone and intercoms (R. p. 308, lines 6-15). He volunteers at two places in Camden where he interacts with the public (R. p. 308, lines17-19) and goes out once a week (R. p. 325, line 22). He also at times stays by himself during some hours of the day. R. p. 327, lines15-17. There are other services available under the waiver that support community living (see the list on R. pp. 892-894), but the Appellant and his family are unwilling to try them. R. pp. 310 & 311. It is speculative at best to assume that the services in place or available are not enough to maintain the Petitioner in the community.

Furthermore, it was never the intention of the Departments to offer 24-hour-a-day care to individuals who participate in the waiver. The first page of the waiver document contains the statement:

> The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.
>
> The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services. Emphasis added

2) In authorizing the Appellant's services, appropriate weight was given to the information submitted by the Appellant's attending physician.

The Appellant would have the attending physician's orders be dispositive of the services provided. It is reasonable, and required, to give, deference to a rendered opinion of a waiver participant's attending physician. However, the Departments must exercise oversight as to the medical necessity of the services ordered and their reasonableness within the limits of service allowed under the program. Surely the Appellant is not suggesting that a service ordered by the attending must be provided even, for example, if the service is not covered at all by the program.

In the case of an able bodied adult, the Medicaid program may limit the services, no matter what the beneficiary's attending physician believes is medically necessary.[2]

In the case of an adult, under the Medicaid program's regulations, at 42 CFR §440.230, all that is required is that the service be sufficient in amount duration and scope as follows:

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

Most recently, this provision was interpreted in Mendocino Community Health Clinic v. State Department of Health Care Services 155 Cal.Rptr.3d 923, 927 (Cal.App. 3 Dist.2013). In that case, the court said:

> For many years, the federal government has allowed, even required, states to adopt utilization controls to insure efficient use of Medicaid funds. "The federal Medicaid Act ... gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.' 42 U.S.C. § 1396a(a)(19)." (*Alexander v. Choate* (1985) 469 U.S. 287, 303,105 S.Ct. 712, 83 L.Ed.2d 661, 673.) The Medicaid Act requires each state to impose "reasonable standards" for medical assistance. (42 U.S.C. § 1396a(a)(17); see also 42 C.F.R. § 440.230 [requiring state Medicaid plan to specify the amount, duration, and scope

[2] That is not true in the case of a child, as explained below. See §1905(r) of the Social Security Act [42 USC §1396d(r)].

> of each provided service].) In *Alexander v. Choate, supra,* the United States Supreme Court held that a state is free under the Medicaid Act to limit the duration of a benefit. (469 U.S. at p. 303, 105 S.Ct. 712.)

In deciding that the Plaintiffs could not show that the reduction violated the standard, the Mendicino court referenced the earlier case of Alexander v. Choate, 469 U.S. 287, 105 S. Ct. 712, 83 L.Ed.2d 661 (1985). In that case, the Supreme Court said:

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

The Appellant also asserts that the orders of his attending physician should be dispositive as to the initial authorization for personal care services under an 11th federal circuit line of cases. But see Moore ex rel. Moore v. Reese, 637 F.3d 1220 (11th Cir. 2011) in which the court found that the treating physician's determination could be reviewed by the State, which had an interest in ensuring that only medically necessary services were provided. We do realize that upon the remand ordered in the circuit court case, the district court roundly chastised the State's experts for their stance, See Moore by Moore v. Cook, 2012 WL 1380220 (N. D. Ga., April 20, 2012). Nevertheless, the holding of the circuit court cannot be denied: that the orders of the attending physicians are not dispositive, and the State has a right to review the attending physician's orders to ensure that only necessary services are covered by the Program. The Georgia line of cases involved a child, not an adult.

If the Appellant were a child, under the EPSDT provisions, and if the services he wants were medically necessary, they would have to be provided under the Medicaid program, even if the services were not covered under South Carolina's Medicaid program. EPSDT is the acronym for early and periodic screening, diagnosis and treatment, described at §1905(r) of the Social Security Act [42 U.S.C.§1396d(r)]. Under that service, children are to be screened for medical problems according to professional screening schedules and be provided vision, dental, and hearing services. In addition, under §1905(r)(5), children are to be provided "...other necessary health care, diagnostic services, treatment or other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses discovered by screenings,...".

Every State has to cover certain of the listed services in §1905(a), but a State can cover some or all of the listed optional services. Nevertheless, even if the State should choose to cover none of the optional services, under the EPSDT provisions, they would have to cover any optional service determined to be medically necessary for a child.

Thus, under the Georgia line of cases, the court was applying the medical necessity standards. If the services were determined to be "medically necessary" for the child, the services had to be provided, if they could be provided under any Medicaid Program. The medical necessity standards do not apply to limiting services to adults. The general analysis in adult cases only goes to whether the limitation in services still provides sufficient services. Under the general rules of the Program, the Respondent has the responsibility to control the utilization of services and limit them to those that are

medically necessary. See 42 CFR §440.230 and Part 456, especially Subpart A. Simply authorizing services without performing a review is antithetical to those regulations.

As to disabled adults, then, what is the role of the attending physician's orders? At least in the case of the mentally impaired, the Olmstead case gives us a glimpse of the Court's preference in a concurring opinion – Kennedy and Breyer.

These two Justices were concerned that in deinstitutionalizing mentally ill patients, the States would place them in situations "...devoid of the services and attention necessary for their condition.....It is of central importance, then, that courts apply today's decision with great deference to the medical decisions of the responsible, treating physicians and, as the Court makes clear, with appropriate deference to the program funding decisions of state policymakers." Olmstead, at 610. (Emphasis added)

To their credit, treating physicians are natural advocates for their patients, and that is as it should be and central to the doctor/patient relationship. However, in their advocacy for their patients, treating physicians are often unmindful of the true availability of services under the various programs, much less the cost of the services they order. Furthermore, although their training is extensive, not every physician is aware of the evidence-based approaches that have been shown to be effective in the area of home-based or community services. Every order received from a treating physician should be given the utmost consideration and attention by State agency staff charged with authorizing services, but services not covered or varying widely from the normal scope which experience has shown to be adequate and varying from program limits should not be authorized.

Again, waiver services, particularly, are designed to "...complement and/or supplement the services that are available to participants through the Medicaid State Plan and other federal, state and local public programs as well as the supports that families and communities provide." See Page 1 of the waiver document.

In this case, there has been no direct testimony by any of the Petitioner's attending physicians. Although an attending physician's affidavit was entered into the Record (R. p. 920-922) for its probative value, it is still fundamentally hearsay evidence. Since the hearing in this case, the Supreme Court has clarified the issue of hearsay evidence in administrative hearings, including probable cause hearings. The Court found that the Rules of Evidence, which are applicable in administrative hearings, expressly exclude the hearsay testimony. South Carolina Dept. of Motor Vehicles v. McCarson 391 S.C. 136, 705 S.E.2d 425 (S.C.,2011).

The Respondent's witness, Ms. Dawn Shealy neither determined what medical services were necessary nor made a medical determination of the risk of institutionalization. The limitations were applied across the board in accordance with the terms of the waiver documents. Her primary testimony was regarding the Service Coordinator's request for an increase in respite services. As to that, she merely applied the waiver limits as she was instructed to do according to the application at R. pp. 158-166. There is no evidence in the Record as to whether Dr. Joseph provided any information before he prepared his Affidavit on May, 10, 2010, the day before the hearing. Ms. Shealy was only making a

program decision by applying the waiver limits. She did testify that she looked at the Appellant's care and support plans. R. pp. 286-287.

3) Providing the Appellant services in the amount that he wishes would fundamentally alter the nature of the Respondent's program;

Under Olmtead, States are required to provide community-based treatment for person with mental and related disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. Olmstead, at 587.

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

Sec. 35.130 General prohibitions against discrimination.

> (a) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.
>
> (b)
>
> .....
>
> (7) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

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

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

Thus, the courts have acknowledged the fundamental alteration defense in applying the rules in Olmstead. In essence, consideration must be given to the cost of the services, and the impact on the State's ability to continue to provide care for others in its charge. The Departments submitted a proper waiver renewal describing the types and limits of services available under this waiver. The renewal (including the limits) was duly

evaluated and approved by CMS. The DDSN has responsibility, under the waiver and under State statutes, not only for providing services to the Appellant, but to all of the other participants in the waiver and all intellectually disabled and those with related disabilities. In order to equitably apportion services, the Department must be allowed to reasonably limit otherwise "boundless" services. In short, it is obvious that if the Department spends too much on any one participant, others accessing DDSN care will suffer.

To permit waiver participants to circumvent the established limits when they can show that the limits have a mere tendency to nudge them toward institutionalization is to fundamentally alter the program by eviscerating the limits.

Throughout his Brief, the Appellant has used dated audit information, isolated schedules, and previous management reviews to allege that appropriations and other funding were diverted from providing direct community waiver services. The audit and management findings are alleged to substantiate that DDSN stands to benefit by restricting access to community based services and thereby encouraging clients to enter institutional care, which the Appellant defines and any environment other than home. Rather than attempting to refute facts that are not in evidence, we simply assert that the Appellant makes too great a cognitive leap from previous reports to nefarious motive. We believe that the Appellant has not established the necessary connection.

4) The 2010 reductions were lawful and not violative of the South Carolina Administrative Procedures Act;

Under a line of administrative decisions beginning with the Administrative Law Court's Decision in Hickey v. SCDHHS (10-ALJ-08-0656-AP), the Appellant believes that the waiver limitations have been found to be unenforceable as un-promulgated binding norms.

First of all, even if the Hickey case is controlling, a careful reading of the case means not that the waiver limitations are unenforceable, as asserted by the Appellant, but only that they are not binding norms and therefore may not be enforced without an opportunity for an evidentiary hearing.

Furthermore, since the Hickey case, in Doe v. SCDHHS, cited above, the SC Supreme Court seemed to indicate that waiver provisions are enforceable with respect to the administration of the waivers, even though they are distinguishable from promulgated regulations. See page 74 of the S.C. version. Footnote 7 of the opinion does say that a policy cannot contradict a regulation and in that posture should be given no effect, but we know of no contrary regulation or law specifying the level of services provided to participants of this waiver.

Finally, the Department's promulgated regulations, at S.C. Code Ann. R. 126-300(D), include, by reference, the waiver approvals issued by CMS as federal directives. The regulation states:

> D. Services are subject to limits and procedural requirements described in the South Carolina State Plan for Title XIX (Medicaid), provider manuals, Medicaid Bulletins, and federal directives.

5) The Appellant was afforded adequate due process.

The Appellant has asserted that the initial notice to the Appellant was defective because it did not comply with the following regulation in Title 42 CFR:

> §431.210 Content of notice.
>
> A notice required under Sec. 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain--
> (a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
> (b) The reasons for the intended action;
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
> (d) An explanation of--
> (1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
> (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
> (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Specifically, the Plaintiff complains that the notice does not set forth the specific "regulations that support...the action."

Ultimately, the "regulations that support... the action" are set forth in the general description of the home and community based waivers in 42 CFR §440.180 of the Medicaid Regulations:

> 440.180 Home or community-based services.
>
> (a) Description and requirements for services. ``Home or community-based services'' means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.
> (1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by CMS.
> ..... (emphasis added)

Obviously, that is a very general, over-arching and abstract concept, and, thus it is much more meaningful for a participant to be apprised of the particular service and service limits in the waiver that apply to the particular action being taken by the agency. It is also much more concretely contestable than the general statement in the actual federal regulations. Under the wording of the federal regulation at 42 CFR §431.210, it would have been permissible to simply have set forth the general statement in §440.180.

We believe that the public hearings on the changes that took place in and the communications by the Service Coordinators (R. pp. 292 & 293), gave the Appellant actual notice of limits. Furthermore, the fact that he, through counsel, sought a reconsideration of the limits two (2) days before they became effective indicates that Appellant did have actual knowledge of the effects that the limits would have on his services. Finally, we believe that the Reconsideration decision and notice of appeal rights issued by Dr. Buscemi (R. pp. 940 & 941) provided adequate notice of the issues and the opportunity to be heard by the DHHS Appeals Division.

The Appellant complains that impermissible Ex parte communication took place between SCDDSN and the Director of the Appeals Division, in violation of S.C. Code Ann. §1-23-360, entitled "Communication by members or employees of agency assigned to decide contested case." (Emphasis added.) The communication complained of was a memo from an employee of DDSN to the Director of the Division of Appeals and Hearings. R. p. 335. The memo stated what services the Appellant had been getting and how the waiver limitation would change those services. The Director of the Appeals Division was not the person assigned to make the findings of fact and conclusions of law in this case. Even if he had been the person, it goes against reason that the adjudicator cannot find out what the posture of the case is before issuing a Notice of the Hearing. Furthermore, we fail to see how that communication can be shown to have prejudicial the Appellant.

6) The DHHS provided services with reasonable promptness, it is the adequacy of those services that is in dispute.

42 USC §1396a(a)(8) provides as follows:

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

Since March 23, 2010, under the Patient Protection and Affordable Care Act (ACA, Pub.L 111-145) the definition of "medical assistance" in 42 USC §1396d(a), has read as follows:

> (a) The term "medical assistance" means payment of part or all of the cost of the following care and services **or the care and services themselves, or both.** (Amendment by ACA emphasized.)

In Doe v. Kidd II, an unpublished opinion at 419 Fed. Appx. 411 (4th Cir., 2011), the court did indeed find that the Respondent (and DDSN) did not provide Doe with agreed upon services with reasonable promptness. However, to add an important point about the services in Doe: they were services that the Respondent had already agreed should be provided to Doe. Here the level of services is the basis of the dispute. The Doe case in no way stands for the proposition that the Appellant should get whatever he thinks he needs with reasonable promptness. The Doe case only requires reasonably prompt provision of services that the State agrees should be provided. The Appellant misapplies the reasonable promptness provision to the waiver services he wanted to maintain.

The rule applies to the reasonably prompt provision of what the Program authorizes. Obviously, the applicant can dispute, through an administrative appeal, the scope of the authorization, but the applicant does not automatically get anything he additionally requests while the appeal is pending.

7) The Respondent did not violate the comparability requirements of the Medicaid Act.

Section 1902(a)(10)(B) of the Social Security Act [42 USC §1396a(a)(10)(B)] provides essentially that the amount duration and scope of services available to one person in an

eligibility group must be available, under the program, to all individuals in the same eligibility group. For example, all individuals eligible by virtue of their Supplemental Security Income (SSI) award must have access to the same array of services. Not at issue in South Carolina, since we do not have a medically needy program[3], the law also prohibits a state from offering services to the medically needy that are not available to the categorically needy.

The implementing federal regulations in 42 CFR provide:

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

One of the exceptions referenced in §440.240 provides:

> § 440.250 Limits on comparability of services.
>
> .....
>
> (j) If CMS has approved a waiver of Medicaid requirements under §431.55, services may be limited as provided by the waiver.

The services at issue here are manifestly offered under a waiver as referenced in the regulations. Therefore the comparability provisions do not apply. Even if the waivers were not excluded, the regulation (§440.240) clearly requires comparability within the State Plan, the contract with the federal government that describes the State's Medicaid Program. It does not deal with occasional settlements the Department from time to time

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3 A state may choose to cover those whose medical expenses, if subtracted from their income and resources, would put them below the State's financial eligibility criteria.

may choose to enter.

CONCLUSION

The Decisions of the Hearing Officer and ALC should be affirmed to allow the limitations in the waiver to take effect, understanding that should a problem arise, the Appellant does, at all times, have recourse to the Service Coordinator and all of the other services available within the waiver, including respite services.

Respectfully Submitted,

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Columbia, SC
August 1, 2013

STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Carolyn C. Matthews, Administrative Law Judge

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

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent

CERTIFICATE OF COMPIANCE WITH RULE 211(b)

I hereby certify that the enclosed Brief of Respondent complies with the requirements of Rule 211(b) SCACR.

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