

Department's Motion.² On December 18, 2013, the Appellant appealed the Hearing Officer's (HO) November 19, 2013, Final Order. On December 23, 2013, the HO denied the Department's Motion for Reconsideration. The Department then timely filed a cross-appeal with this court on January 16, 2014.

The Hearing Officer determined that the Appellant was to receive nursing services to the extent allowable under the HASCI Waiver program and that the service coordinator was to assist in procuring those services. The Hearing Officer also determined that the Appellant's mother was to be paid \$140,148.60 (per the table found at page 33 of this Order) for care she provided to the Appellant during the pendency of her appeal, and that the Department would reimburse the Appellant's mother \$8,318.80 for the cost of a speech generating device that she had purchased after the Department refused the purchase request from the Appellant's physician.

The Department filed the Record on Appeal on April 1, 2014. The Appellant filed a Petition for an Order of Contempt and Rule to Show Cause on May 1, 2014, requesting that this court "immediately order DHHS to comply with the order of hearing officer Hutto while this appeal is pending. Brook petitions this Court for an order holding DHHS in contempt and a Rule to Show Cause."³ The Department cited to SCALC Rule 34, which dictates that the "filing of an appeal from the final decision of an agency shall stay the final decision of that agency unless the effect of filing an appeal is otherwise established by statute, the Administrative Procedures Act notwithstanding; or the administrative law judge has entered an order regarding the effect of the proceedings in the agency."

This court held a hearing on the Appellant's Petition for an Order of Contempt and Rule to Show Cause on June 12, 2014, and consolidated the Appellant's appeal and the Department's cross-appeal on June 13, 2014.⁴ Shortly thereafter, on June 23, 2014, the Appellant's counsel filed a "Petition/Complaint for Remedial Writ" and argued that filing a notice of appeal does not stay enforcement of the agency decision under the provisions of S.C. Code Ann. § 1-23-380 as well as

² The Appellant's attorney electronically mailed (emailed) the Hearing Officer on December 16, 2013 and explained that "[M]y assistant of 20 years retired recently and Rick's motion appears to have been misfiled in my office." An email sent two (2) days later clarified that the legal assistant had retired in September 2013.

³ The Appellant's counsel alleged that this court "is bound to enforce South Carolina Code of Laws §1-23-380, which provides that '...the serving and filing of the notice of appeal does not itself stay enforcement of the agency decision.' DHHS has not filed a motion to request a stay pursuant to Rule 65 of the South Carolina Rules of Civil Procedure. Justice demands, as a matter of law and equity, DHHS should be ordered to immediately comply with the Order of its own agency hearing officer." Additionally, the Appellant's counsel argued that this court should hold the Department in contempt "for a willful violation of a lawful court order."

⁴ The Order of Consolidation dismissed 14-ALJ-08-0088-AP.

Rule 241 of the South Carolina Rules of Appellate Procedure. The Appellant's counsel also requested this court award legal fees and costs.⁵

INTRODUCTION

The Appellant's claim originally began as an appeal on April 28, 2007, just prior to the Appellant's discharge from a transitional care unit in Charleston, South Carolina. Spanning over the course of a decade and consisting of two remands from this court, one remand from the Department and two evidentiary hearings, the Appellant's appeal has metamorphized into a complex web, which "contains a multitude of claims, some of which have multiple subparts... it is easy to see how one variation[]... could be overlooked." *Porter v. Zook*, 803 F. 3d 694, 696 (4th Cir. 2015).

As discussed in greater detail below, a Department HO dismissed the original appeal on November 16, 2007, on procedural grounds. This court subsequently remanded the matter to the Department for an evidentiary hearing on March 2, 2009. The Appellant appealed the matter, yet again, to this court, and this court issued a second remand in July 2012. This matter now involves a cross-appeal filed by both parties on the most recent Final Order dated November 19, 2013.

BACKGROUND

In September 2005, BW was a seventeen (17) year old high school senior on her way to a cheerleading event who was involved in a near-fatal automobile accident that left her a C4-C6 quadriplegic. She was initially treated at Spartanburg Regional Healthcare System but was then transferred to Shephard Center in Atlanta, Georgia for medical management and inpatient physical rehabilitation on November 2, 2005. She had a medically complicated recovery⁶ and spent nineteen (19) months in several different hospitals. The Appellant breathes through a tracheostomy and has had difficulty speaking due to injuries to her larynx sustained during her hospitalization.

The Appellant became eligible for Medicaid-covered services shortly after her accident in 2005, at the age of seventeen (17). Shortly thereafter on January 14, 2006 she turned eighteen

⁵ The Appellant's counsel also sent a letter to the South Carolina Attorney General "out of an abundance of caution," averring that this court "did not consider [her] request to be properly framed." She reported that the Appellant's case "has cycled and recycled between DHHS and the Administrative Law Court for more than seven years now."

⁶ Among other things, the Appellant's recovery was complicated by a persistent tracheal esophageal fistula (R. at 2644 and 2649.)

(18) on January 14, 2006 while still hospitalized.⁷ She began this appeal a few months after she turned nineteen (19) years old. BW turned twenty-one (21) on January 14, 2009, prior to this court's first remand for an evidentiary hearing in March 2009.

Medicaid

Medicaid is a cooperative federal-state program designed to furnish medical assistance to persons "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1 (2010). The Centers for Medicare and Medicaid Services (CMS) administers the program on behalf of the Secretary of the United States Department of Health and Human Services. While states are not required to participate in Medicaid, all of them do. *Ark. Dep't of Health & Human Servs. V. Ahlborn*, 547 U.S. 268, 275, 126 S.Ct. 1752, 164 L. Ed. 2d 459 (2006).

Once a state chooses to participate in the Medicaid program, it must comply with applicable federal statutory and regulatory schemes. Each state must specify a single state agency designated to administer the Medicaid Plan, and in South Carolina, the Department administers the Medicaid Plan. 42 U.S.C. § 1396a(5) (2010); 42 C.F.R. § 431.10(a) and (e) 2-1 (2013); S.C. Code Ann. § 44-6-30 (2014). "Congress has afforded States broad flexibility in tailoring the scope and coverage of their Medicaid programs." *Pharm. Research & Mfrs. Of Am. V. Walsh*, 538 U.S. 644, 686, 123 S. Ct. 1855, 155 L. Ed. 2d 889 (2003) (citing *Alexander v. Choate*, 469 U.S. 287, 303, 105 S. Ct. 712, 83 L. Ed. 2d 661 (1985)). South Carolina has promulgated an extensive regulatory scheme for the administration of its Medicaid program. See S.C. Code Ann. Regs. 126-125, *et seq.* Moreover, the State has developed its own administrative review process and appellate procedures. S.C. Code Ann. Regs. 126-152.

HCBS State Medicaid Waiver Program

The Medicaid HCBS waiver program is authorized by §1915(c) of the Social Security Act. The goal of the HCBS Waiver program is to provide services to persons at home or in the community and thereby avoid placing them in a nursing facility or intermediate care facility. See *Doe v. Kidd*, 501 F. 3d 348, 351 (4th Cir. 2007). The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community

⁷ When a child reaches the age of eighteen (18) in this state, that child is no longer a minor and his or her parents are no longer legally responsible for the care and management of the child. S.C. Code Ann. §§ 44-23-10(7) and 63-5-30.

and avoid institutionalization. The State has broad discretion to design its waiver programs to address the needs of the program's target population. Waiver services complement or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs. 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. 42 U.S.C. § 1396n(c); 42 C.F.R. § 441.300.

The Department contracts with DDSN to operate the HASCI program. S.C. Code Ann. § 44-6-30(1) (Supp. 2012). To participate in the HASCI Waiver program, a person must be Medicaid eligible, must meet listed diagnostic criteria, and must have sufficient independence and/or adequate natural supports to live safely in a private residence or other community setting with the type and amount of services available from the HASCI Waiver, among other things. S.C. Code Ann. § 44-38-370 (2014). The waiver does not provide room and board and is not meant to provide 24-hour care. An individual must be offered the choice between institutional services or home and community-based services, must choose to receive HASCI Waiver services, must be informed of all the alternatives available in the HASCI Waiver, and must choose from among qualified service providers.

Besides the HASCI Waiver program, also relevant to this appeal is the Intellectual Disability/Related Disabilities (ID/RD) Waiver.⁸ The ID/RD Waiver program permits the Department to waive the requirement that individuals with an intellectual disability or a related disability live in an institution in order to receive certain Medicaid services. The HASCI Waiver and the ID/RD Waiver both fall under the joint supervision of the Department and DDSN. Though an eligible individual may qualify for more than one waiver program, the individual is only eligible to be enrolled in one program, not both. Additionally, the average cost of providing waiver services must be equal to or less expensive than the average cost of institutional care. *See* 42 U.S.C. § 1396n(c)(1).

Federal regulation requires that a state's waiver program "must specify the amount,

⁸ The ID/RD waiver was formerly known as the Mental Retardation/Related Disability, or MR/RD, prior to June 2011. The terms are used interchangeably throughout the record. The terms "Intellectual Disability" and "person with Intellectual Disability" have been substituted in state law for "Mental retardation" and "mentally retarded," respectively. Thus, the reference to this waiver as MR/RD is obsolete, and the term has been replaced with ID/RD, which references Intellectual Disability/Related Disability waiver. 42 U.S.C. § 1396(n)(c); S.C. Code Ann. § 44-6-30(1) (Supp. 2016). The ID/RD Waiver program permits states to waive the requirement that persons with intellectual disabilities or a related disability reside in an institutional setting to receive certain medical services. *See Doe v. Kidd*, 501 F. 3d 348, 351 (4th Cir. 2007).

duration, and scope of each service it provides.” 42 C.F.R. § 440.230(a) (2012). Federal statutes expressly authorize states to place limits on services or reduce the amount, duration or scope of a provided service, so long as 1) such reductions are approved by the federal government prior to implementation, and 2) such reductions are not done in an arbitrary manner. Once a waiver program is approved, the waiver remains in effect for a period of three (3) years, but it may be renewed thereafter in five (5) year increments.⁹ 42 U.S.C. § 1396n(c)(3).

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

The federally mandated EPSDT program is a comprehensive health benefit for all Medicaid-eligible children and youth under age twenty-one (21). Though Medicaid allows for states to compose their own definition of medical necessity for adults, EPSDT requires states to provide children and youth under 21 with any “necessary health care, diagnostic services, treatment and other measures...to correct or ameliorate defects and physical or mental illnesses and conditions as covered by the Medicaid Act.” 42 C.F.R. § 435.930. If a child requires EPSDT services, she must receive those services promptly. A youth should be provided with services based on her individual needs, as determined by her doctor or other healthcare professional.

In 1989, Congress strengthened the EPSDT program by requiring states to cover all treatment services (including both mandatory and optional services) listed in the Medicaid statute, which includes private duty nursing services, personal care services, medical supplies and equipment, along with “other diagnostic, screening, preventive and rehabilitative services...and restoration of an individual to the best possible functional level.” 42 U.S.C. § 1396d(a)(13). Significantly, the EPSDT program covers the broadest possible array of Medicaid services. 42 U.S.C. § 1396d(a)(4)(B) & (r). EPSDT is designed to “assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.”¹⁰ In South Carolina, the Department is responsible for administering the EPSDT Program. S.C. Code Ann. § 44-6-30(1) (2014).

Children under age 21 who are enrolled in an HCBS waiver program are also entitled to all EPSDT services, where the HCBS Waiver services “wrap-around” the EPSDT benefit. EPSDT eligible children are entitled to a possible twenty-nine (29) categories of care and services, defined

⁹ After DHHS submits the waiver plan to the federal government and the plan is approved, DDSN is then responsible for the daily administration of the waiver program and its services. S.C. Code Ann. § 44-20-240 (Supp. 2012).

¹⁰ See CMS, U.S. Dep’t of Health & Human Servs., Pub. No. 45, State Medicaid Manual.

as “medical assistance,” including “private duty nursing services” under 42 C.F.R. § 440.80, if the service is “medically necessary.”

Original Appeal dated April 28, 2007

In February 2007, a dispute arose concerning the amount of in-home skilled care and services the Appellant would receive, and that dispute formed the basis of the present appeal. The Appellant’s Medicaid Service Coordinator, Ms. January Gosnell, drafted a service plan for the following in-home skilled care per week: twenty-eight (28) hours per week of Personal Care Aide¹¹ (PCA) Services; fifty-six (56) hours per week of Licensed Practical Nurse (LPN) nursing care; and fourteen (14) hours per week of Registered Nurse (RN) nursing care. The total hours of care provided under the Service Plan totaled ninety-eight (98) hours per week. The RN services were to be evaluated after thirty (30) days but were to continue in some amount per week. Ms. Gosnell’s service plan omitted mention of EPSDT services (Prior R. at 1203), even though the Appellant was nineteen (19) years-old, and as a Medicaid recipient, would have been entitled to EPSDT services.

On March 14, 2007, DDSN issued a HASCI Notice of Denial notifying the Appellant that the request for additional nursing services had been denied for exceeding service limits. The notice stated that BW would already be receiving the maximum amount of RN hours per week and could not receive additional LPN hours.¹²

On March 29, 2007, the Appellant’s treating physician at the Medical University of South Carolina (MUSC), Dr. Gerard Silvestri, determined that the Appellant needed a total of one hundred and twelve (112) hours per week of combined nursing services, because she “must be turned every two hours; she must also be suctioned throughout the day. She requires nebulizer treatments averaging four times per day. [She] also requires medication management, and in-and-out catheterization every three hours...and will require attendant care at all times when a nurse is not present. She requires total assistance in bathing, skin care, transfers, food preparation, and eating.” (Prior R. at 1233.) Dr. Silvestri’s physician’s order required eighty-four (84) hours of

¹¹ A Personal Care Aide is a qualified provider who aids with activities of daily living such as light housekeeping, feeding, clothing and bathing. Only an RN, an LPN or a trained family member may provide skilled care.

¹² (R. at 1601.) The Department’s position was that the maximum number of nursing services/units that can be funded by the HASCI waiver was 60 hours per week provided by an LPN or 44 hours per week provided by an RN, though the Department witnesses seemed very unclear on this point at the time of the evidentiary hearing.

LPN nursing care along with twenty-eight (28)¹³ hours of RN nursing care weekly.

On March 30, 2007, DDSN issued another denial notice denying the requested additional nursing services, stating that "HASCI Waiver services...cannot be offered when it can reasonably be expected that the cost of services to [BW] would exceed the cost of a nursing facility level of care." (R. at 602 and 3278.) Additionally, the block entitled "Exceeds Service Limits" was also checked, and the form was signed by January Gosnell, DDSN Service Coordinator. On April 28, 2007, the Appellant appealed, in part, the denial of the requested additional nursing and attendant care services prescribed by her treating physicians.¹⁴ (R. at 3282.) The Appellant did not include the HASCI denial notification with the appeal letter.

In addition to appealing the denial of nursing services under the HASCI Waiver, however, the Appellant also alleged that the state failed to provide the Appellant with services under the HASCI Waiver in the least restrictive setting, including but not limited to, nursing services, attendant services, psychological services, assistive technology devices, and other services for which the Appellant was eligible to receive. She also alleged in the letter that the "State has failed to offer these services with reasonable promptness." (R. at 3282.) Additionally, the Appellant argues that: (1) the State "had failed to notify Brook Waddle of her eligibility for services under the MR/RD Medicaid waiver and to offer these services in the least restrictive setting with reasonable promptness; (2) the State "failed to perform PASAAR¹⁵ assessment and specialized services as required by federal regulations prior to attempting to discharge [the Appellant] to an institutional setting; (3) "the State has failed to provide EPSDT services as required by the Social Security Act and federal regulations"; (4) the State "has improperly limited the hours of services

¹³ Though the Hearing Officer indicated the number of RN hours was twenty-four (24) weekly hours, at page 7 of her Final Order this is a clerical error, since it conflicts with the rest of the Record on Appeal. The number should be fourteen (14) hours of RN care weekly. (See R. at 9.)

¹⁴ In her letter of appeal addressed to the Office of Appeals and Hearings, as well as DDSN and the Director of the Department, the Appellant's counsel stated she had "delayed filing this appeal in hopes that these issues would be resolved within 30 days of DDSN's March 30, 2007 denial of nursing services. Unfortunately, these services are still not in place. During this appeal, we are willing to work with both agencies toward returning Brook to her home community. However, we are requesting a final administrative determination within 90 days as required by 42 CFR 431.244." (R. at 3185.)

¹⁵ PASARR is the acronym for preadmission screening and annual resident review, as set forth in Section 1919(e)(7) of the Social Security Code. 42 USC §1396r(e)(7) and 42 CFR § 482.100 *et. seq.* The rule requires assessments designed to prevent inappropriate admissions to nursing facilities of individuals who are mentally retarded or who are mentally ill. By definition, PASARR only applies to individuals who are admitted to a nursing facility. The Appellant was receiving services at home under the HASCI Waiver, and therefore, the PASARR issue was not relevant. As this court found in its Remand Order, "the Hearing Officer had been informed that Ms. Waddle was offered homebased services under the HASCI waiver. Therefore, it could have appeared to the HO that the issue was moot or irrelevant, since it was presumed that the Appellant was going to live at home and was not being admitted to a nursing home."

offered to [the Appellant] in violation of the Social Security Act and federal regulations”; and (5) “the State has acted erroneously in denying requested services in violation of applicable federal case law and regulations.” (R. at 3282-3283).

On or about May 8, 2007, the Department approved Ms. Gosnell’s service plan hours listed in the February 2007 plan, which consisted of the original ninety-eight (98) hours of weekly care (56 LPN hours; 14 RN hours and 28 PCA hours). The Appellant’s counsel stated she “conditionally accepted the services...[but] reserves all rights” in a letter, dated May 9, 2007, because those services were not what the Appellant’s treating physician believed were medically necessary.¹⁶

First Hearing Officer Determination—Dismissal Order

On June 11, 2007, the Department HO ordered a Prehearing Conference and relayed that “[t]he nature of the controversy in this matter is unclear” due to the fact that the Department approved services and the Appellant accepted services. The purpose of the prehearing conference was also to simplify the issues, expedite the hearing process, and afford the parties a chance to identify the “justiciable issues.” The HO further required the Appellant to prepare a written Memorandum of Understanding (MOU) memorializing the results of the prehearing conference, “approved as to form and content by the Department and to provide a finalized copy to the HO within ten (10) days following the conference.”¹⁷ The HO also ordered the Appellant to submit

¹⁶ The letter reiterated the Appellant’s physicians “have agreed that she requires someone in attendance at all times who is capable of suctioning and catheterizing her. Please be advised that we do not believe that the service restrictions which DDSN and DHHS have imposed on Brook are legally appropriate. Therefore, Brook reserves all rights. Her acceptance of services in order to secure her release from her current, considerably more expensive institutional placement cannot be construed as a waiver, consent, limitation, estoppel or other indication of agreement with the restrictions imposed by DDSN and DHHS.” (R. at 3285-3286.) The letter also informed the Department that “flexibility is needed to accommodate the needs of Brook and her family, as well as the needs and obligations of potential employees, once she returns to her community. Brook and her family need to be able to provide longer nursing shifts on fewer days in order to obtain the needed nursing services.” (R. at 3286.)

The cost of approved RN hours per month amounted to \$1,824 per month (30.4 days x 2 hours day x \$30); the cost of approved LPN hours in the plan of care was \$4,864 (30.4 days x 8 hours daily x \$20); the cost of PCA services would be \$1,580 per month (30.4 days x 4 hours day x \$13). The total monthly cost to the agency would be \$8,268. Further, the Appellant requested that the family’s physician should be allowed to allocate how the \$8,268 per month was divided between RN, LPN and PCA services, because this was in keeping with DDSN’s “person-centered philosophy.” According to the Appellant, the base cost in a transitional care unit in Charleston was \$11,400 monthly, which did not include ancillary costs, such as physician, respiratory, and other services.

¹⁷ The HO provided no explanation of what a “pre-approved” MOU might require or would accomplish, but stated she believed the “pre-approved MOU” was necessary “to avoid the filing of a document containing errors.” (R. at 3266.) The court cannot determine why the HO believed the submission of an “MOU approved as to form as substance” would have changed the answers she received, which were, in essence, that the parties were at odds on the number of issues on appeal, but that the Department’s position was that the single issue was resolved.

the HASCI denial notice before June 19, 2007, since the Appellant had not included that with her appeal letter.

The HO's order required the Department to arrange the pre-hearing conference. The telephonic conference occurred on June 26, 2007, and on July 5, 2007, the Appellant sent by facsimile transmission the Respondent and the HO an MOU, stating that the Appellant believed the Department's position was that "all issues...have been resolved." The Appellant re-stated that her position remained the same, and she referenced her April 28, 2007 appeal letter.

On July 5, 2007, the Department reported to the HO that the Appellant had violated the requirement to have the MOU "preapproved as to form and content" and that the Appellant had mischaracterized the Department's position, which was not that all issues had been resolved, but that the only issue ever on appeal was the denial of HASCI nursing services, and that this issue had been resolved when services were provided to the Appellant.¹⁸ The HO issued an Order to Show Cause six weeks later, on August 17, 2007, requiring the Appellant to explain by no later than September 10, 2007, why the case should not be dismissed because she failed to file an MOU approved as to form and substance along with other questions.¹⁹

The Appellant argued the HO's continued pre-hearing demands were unjustified and violated federal regulations as well as the Appellant's due process rights.²⁰ (R. at 1745.) She

¹⁸ The Department's clarification of its position appears similar to the position the Appellant related to the HO in her MOU, which was that no issues remained for resolution. The Department further clarified to the HO that its position was that the "only issue on appeal was the denial of nursing services through the HASCI waiver, as evidenced by the denial notice...and that [n]ursing services have been authorized and this issue has been resolved." The Department also clarified that "the other matters stated...in the MOU are not properly before you in this appeal." (R. at 3272.) The court disagrees that the Department's brief response contradicting the Appellant's MOU was a great burden for the Department to generate and submit; however, the court also disagrees with the Appellant's counsel's characterization of the requirement for obtaining a pre-approved MOU to asking Hercules to go to Lerna and slay Hyrda, a nine-headed swamp creature. (R. at 1749.)

¹⁹ Those questions were as follows: The Appellant was to show cause with supporting documentation 1) why the alleged remaining issues in this matter should not be dismissed due to alleged failure to file a MOU approved as to form and content by the Department, 2) why the allegation of failure to provide nursing services with reasonable promptness should not be dismissed as moot; 3) why the allegation of the Respondent's failure to notify the Appellant of MR/RD Waiver eligibility and failure to offer services with reasonable promptness should not be dismissed as improperly before the Hearing Officer? Provide documentation evidencing the date of the request/application for MR/RD Waiver services; 4) Why the PASSAR allegation should not be dismissed as moot or improperly before the Hearing Officer; 5) Why the EPSDT allegation should not be dismissed as improperly before the Hearing Officer, and 6) why the allegation of a limitation of service hours should not be dismissed as improperly before the Hearing Officer. (R. at 3267-68). The HO ordered that "upon receipt of the [Appellant's] answer(s) to this Show Cause Order and the Respondent's Reply, the Hearing Officer will rule based on the filed documents and applicable law." (R. at 3268.)

²⁰ She further protested that obtaining approval as to form and substance of the MOU was a Herculean task that had to be done in six working days, a task she likened to Hercules being "ordered...to slay Hydra, a nine-headed swamp creature. Requiring [Appellant's] counsel to go into the Congaree Swamp to find and slay such a creature would be a more manageable task than obtaining Respondent's approval of a 'Memorandum of Understanding' in just six

further argued that the HO's demands were time consuming and burdensome and that the HO had no authority to impose such requirements. (R. at 1746.) She posited that her appeal was not moot simply because she accepted fewer nursing hours than her treating physician, Dr. Silvestri, determined was "medically necessary" or that she had lost her right to appeal "all of the claims contained in her April 28, 2007, appeal."²¹ (R. at 1743 and 1747.)

Further, the Appellant argued that, absent her withdrawal of her appeal in writing or her failure to appeal at a scheduled hearing without good cause, the HO was without authority to "dismiss this appeal without providing [BW] a hearing at which she will have the opportunity to bring witnesses, to establish pertinent facts and circumstances, to present an argument without undue interference and to question or refute any testimony or evidence...." 42 U.S.C. § 431.223 and 42 C.F.R. §§ 431.242(b)-(e). She argued that 42 C.F.R. § 431.200 mandates the Department must provide a fair hearing "for any person whose claim for assistance is denied or not acted upon promptly." Since the Appellant requested a fair hearing, the Department was required to "take final administrative action within 90 days...." 42 C.F.R. § 431.244(f); (R. at 1743-1751.) The Appellant also argued that Regulation §126-152(B) did not require individual Medicaid recipients to provide a more definite and certain statement when requesting a fair hearing, and that the South Carolina General Assembly chose not to include "these more stringent requirements for individual Medicaid recipients who request a fair hearing," which she argued was only a requirement for Medicaid providers. (R. at 1747.)

The Department replied on September 24, 2007 and argued the HO should dismiss the Appellant's appeal under the provisions 27 S.C. Code Ann. Regs. 126-154 (1976). It argued that the sole issue on appeal was the March 30, 2007, denial of nursing services under the HASCI Waiver, and that those services had been ultimately granted at the Appellant's discharge from the

working days." (R. at 1749.) The Appellant also noted, however, that she sent a facsimile transmission of the MOU to the Department at 4:19 a.m. on July 5, 2007. (R. at 1748.)

²¹ The Appellant also argued that in the few weeks since her discharge from the transitional care unit, she "has been hospitalized twice since this appeal was filed. One hospitalization lasted more than three weeks. [BW] was readmitted to ICU on September 7, 2007, reportedly due to a complication which could have been avoided had the requested medically necessary services been put into place with reasonable promptness." The Appellant's counsel provided no further details on the reasons for the hospitalizations in her presented materials. (R. at 1745.) The Appellant also argued that as "a result of the State's denial of requested augmentative communications device, [BW] has been unable to communicate effectively with her medical care providers, attendants and nurses. She has been unable to attend physical therapy because of the failure of HHS to provide safe transportation to and from the outpatient rehabilitation facility. Because of her inability to communicate effectively and as a result of the State's failure to provided (sic) other medically necessary services and items, Petitioner's medical condition has deteriorated significantly." (R. at 1746.)

hospital, on or about May 8, 2007. The Appellant's acceptance and receipt of nursing services meant that her allegation should be dismissed as moot; that her allegation that MR/RD Waiver services had not been offered in the least restrictive setting with reasonable promptness should be dismissed because the Appellant had produced no documentation evidencing the date of her request/application for MR/RD Waiver services, other than documents she herself generated/created in emails or letters.

The Department additionally argued that the Appellant was required to specifically allege which services the Appellant had been denied under EPSDT, because EPSDT was a program under which several services are covered for those Medicaid eligible individuals under age 21, and that broadly alleging EPSDT services had not been offered to the Appellant in the least restrictive setting with reasonable promptness was not enough.

On November 16, 2007, the hearing officer issued an Order of Dismissal without holding an evidentiary hearing under the provisions of 27 S.C. Code Ann. Regs. 126-154 (1976).²² The hearing officer found that the Appellant's failure to submit an "MOU approved as to form and substance rendered the matter properly subject to dismissal" because her failure to submit the approved MOU had required the Department to "submit a letter clarifying its position" which would not have otherwise been necessary.²³ Although she held no evidentiary hearing, the hearing officer elected to address all of the issues raised by the Appellant. Specifically, she noted the denial of nursing services occurred on March 30, 2007, and subsequently, on May 9, 2007, DDSN approved nursing services, and therefore the hearing officer determined the Department had rescinded its denial and the issue of HASCI nursing services was moot.²⁴ The HO also found that,

²² This regulation provides:

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

²³ This court notes, once again, that the Department asserted the issue had been resolved and the Appellant disagreed.

²⁴ The Findings of Fact were also that the Appellant was "being provided nursing services...consequently, there is no basis to the allegation that the State is failing to furnish services with reasonable promptness...." The HO also found that, after the Department's later determination to grant the Appellant nursing services under the HASCI Waiver, the March 30, 2007 denial of services "was no longer an initial determination from which the [Appellant] could take an appeal" and "consequently the [Appellant] no longer had a right to a hearing on the SCDDSN March 30, 2007 denial of nursing services." (R. at 3111-12.)

with regard to EPSDT, the claim was not ripe because the Appellant had not alleged what EPSDT services she had requested and was denied.²⁵

Appeal to Administrative Law Court – December 2007

The Appellant timely filed a Notice of Appeal with this court on December 17, 2007, and alleged denial of her right to a fair hearing pursuant to 42 U.S.C. § 1396a(a)(3), 42 C.F.R. § 431.220, and 42 C.F.R. § 431-244; and that the Hearing officer violated the Appellant's Federal Constitutional right to due process by refusing to grant a fair hearing.²⁶

On March 2, 2009, this court issued an Order of Remand without ruling on the appropriateness of the Hearing Officer's dismissal. The court remanded the case for an evidentiary hearing and found that the "[s]ignificant impasse seems to have been the failure to produce a 'Memorandum of Understanding' as requested by the Hearing Officer."²⁷ (R. at 1692.) The court held that "it is in the interest of judicial economy that this case proceed on its merits, without assessment of blame, by Appellant providing the information described below to the Respondent, the Hearing Officer and this Court." The Remand Order required the Appellant to "fully and completely answer the questions posed herein, in writing, and serve the same upon Respondent and file a copy thereof with this Court. That upon such service and filing, this matter is hereby remanded to the Division of Appeals and Hearings of the S.C. Department of Health and Human Services for hearing within forty-five days of this Order."

Second Hearing Officer Determination – July 9, 2009

The same Department Hearing Officer timely held an evidentiary hearing on April 14, 2009 and issued a Final Order on July 9, 2009. The Hearing Officer's Final Order did not list which

²⁵ The court notes that the Order of Dismissal contained a section "findings of fact" which the court will not consider, since the HO's order was not a Final Order and Decision following an evidentiary hearing such as would permit the Hearing Officer to engage in fact finding. (R. at 3205-3208.)

²⁶ The Respondent argued in its brief that the Hearing Officer had the authority to dismiss the appeal under Regulation 126-154, and that 42 U.S.C. § 1396a(a)(3) was not violated because the Appellant – though she was provided an opportunity for a fair hearing – chose not to avail herself of that opportunity by failing to comply with Hearing Officer's Orders of June 11, 2007 and August 17, 2007, respectively. It was only because the Appellant failed to comply with the Orders and the fact that nursing services were authorized, accepted and received that the Hearing Officer properly dismissed the appeal. Regarding the Appellant's argument that 42 C.F.R. § 431.223 prohibits the Hearing Officer from dismissing an appeal for any reason other than a withdrawal in writing or failure to appeal at a hearing without good cause, the Respondent argued that this is in contravention to the permissive language found in the regulation. Lastly, the Respondent argued that the HO could not have violated 42 C.F.R. § 431.244(a) because that regulation clearly governs "hearing decisions" and since the HO dismissed the matter prior to a hearing, that provision was inapplicable.

²⁷ The Honorable John D. McLeod, formerly of this court, held a hearing in this matter on January 14, 2009, and in preparation for issuing the Order, asked the Department to identify the remaining issues based on the Appellant's April 28, 2007, letter of appeal.

witnesses testified at the hearing, or point to any evidence in the record, but summarily concluded that “[t]he [Appellant] did not establish that EPSDT was appropriate.” (R. at 3343.) The Hearing Officer made this conclusory finding, despite earlier reciting that “[t]he Petitioner, as a Medicaid recipient under the age of 21, was entitled to any Medicaid reimbursable services that are medically necessary.” (R. at 3340.) The Hearing Officer also discussed that “with respect to ESPDT, the Appellant was requesting payment for nursing services, as required by the Appellant’s attending physician, to include: safe transportation; assistive communication devices; reasonable and prompt provision of attendant care services, not subject to unreasonable limitations.” (R. at 3340.)

With regard to the HASCI waiver of nursing services issue, the Hearing Officer found that the “nursing services provided by Respondent, as authorized and limited were appropriate; and provided with reasonable promptness.” (R. at 3340-41.) Individuals wishing to make application for medical assistance shall have the opportunity to do so, and such assistance shall be furnished with reasonable promptness to all “eligible individuals.” The Hearing Officer did not point to any testimony that led her to this conclusion, nor did she list which Department witness testimony supported the finding.

Lastly, the Hearing Officer issued detailed findings concerning the Appellant’s ID/RD waiver eligibility, finding that the Appellant was: wheelchair bound; frequently had to have her airway suctioned; that her speech clarity was inaudible and must be interpreted by another; that she required care for all of her needs; that her condition was “severe, chronic, and resulted in impairment similar to that of persons with mental retardation, manifested before age 22 years” and was likely to continue indefinitely and result in substantial limitation in all areas of major life activity including self-care, learning, mobility, self-direction and capacity for independent living. (R. at 3342.) The Hearing Officer concluded that the Appellant established she had a “Related Disability” and that she had made a service request through the DDSN Service Coordinator, and therefore, the HO remanded on this issue. (R. at 3346.)

Based on the findings, the Hearing Officer affirmed in part, reversed in part and remanded for a full MR/RD waiver eligibility determination.

Second Appeal to the ALC – August 2009, Second Remand Order – July 2012

Despite the interlocutory nature of the Hearing Officer’s Order with regard to the ID/RD waiver eligibility issue, which the Hearing Officer remanded to the Department, the Appellant

filed a second appeal with this court on August 10, 2009.²⁸ Specifically, the court noted the Appellant alleged the Department violated the Medicaid Act by: 1) “failing to inform and provide Appellant with ‘feasible alternatives²⁹ under the waiver’ as required by 42 U.S.C. § 1396n(c)(2) and 42 C.F.R. § 441.302(d)(1)”;³⁰ 2) that the Department violated the Appellant’s “right to receive Personal Care Services (Attendant Care) from her choice of provider as required by 42 U.S.C. 1396a(a)(23) and 42 U.S.C. 1396d(r)(EPSDT) and her right to have Medicaid pay her mother to provide these services”; and 3) that the Department violated “EPSDT and other provisions of the Medicaid Act by refusing to pay for an augmentative communications device (sic) which Brook’s treating physician prescribed that was determined to be medically necessary by a qualified speech and language pathologist and for attendant care services provided by [BW’s] mother”; and 4) whether the Department had violated the Medicaid Act and the American Recovery and Reinvestment Act by reducing the Appellant’s Medicaid services.

On July 30, 2012, the same Administrative Law Judge (ALJ or ALC) once again remanded the matter and found that the HO failed to make specific findings concerning the level of services the Appellant needed as well as the “the adequate and practical number of nursing hours required by the Appellant.” (R. at 3368-2269, Remand Order at page 7.) The ALC found that the evidence in the record – in the form of testimony from Service Coordinator January Gosnell and in the form of an Affidavit from the Appellant’s treating physician, Dr. Gabel – reflected that Ms. Gosnell was mistakenly operating under the assumption that Dr. Gabel had ordered fewer hours of nursing services (32 hours of LPN care, and 40 hours of Attendant care) than he actually had, and that Dr. Gabel believed that the Appellant required “much more service.” The ALC also noted that, though Dr. Burton, the Department physician, testified that “he reviewed the Appellant’s level of care

²⁸ With regard to the MR/RD eligibility issue, this court has therefore, never received a final agency decision on this issue. Simply because the Appellant may be eligible for both waiver programs does not mean she can simultaneously be in both programs—in fact, the Department allows a recipient to be enrolled in only one waiver program. If the Appellant wanted to avail herself of the ID/RD waiver program, the matter should have been finally ruled upon by the HO, rather than being instantly appealed to this court, prior to the issuance of a Department decision on the remanded issue. See *Porter v. Zook*, 803 F. 3d 694, 696 (4th Cir. 2015).

²⁹ With regard to the feasible alternative issue that the HO had ordered remanded, the court “saw no reason to disturb that determination” and ordered the Respondent to “fully process any application of the Appellant to seek services under one or the other Waiver, whichever she chooses.” (R. at 1367.) As already stated, this court has no final decision from the agency as to this issue and declines to rule on this issue.

³⁰ The Appellant alleged this was done “by failing to provide Home and Community Based Waiver services in such amount, duration and scope as is necessary to achieve the purposes of the program as required by 42 C.F.R. § 440.230(b)...” and that the Respondent did not provide the Appellant these services with “reasonable promptness” as required by 42 U.S.C. § 1396a(a)(8).

with the staff and doctors at MUSC and determined that the general support that she was getting was adequate to allow her parents to work and have some free time on the weekends," the Hearing Officer's failure to make specific findings on this issue required yet another remand.³¹

Accordingly, the ALC remanded the matter to the Department again to answer the following five (5) questions:

- 1) The weekly hours of RN care the Appellant needed taking into consideration the practical scheduling concerns of qualified providers in the geographical vicinity of the Appellant.
- 2) The specific type of care and number of weekly hours of each type of care required during the course of her treatment since her discharge in May 2007 consistent with the Medicaid program, and the principle that the mother is not legally responsible for caring for the Appellant.
- 3) The number of hours of the authorized care described in #2, above, that has been provided by the mother (according to her qualifications), and the cost of that care, which amount shall be paid to the mother.
- 4) In the future, the mother should be allowed to provide whatever care she is qualified to provide within the authorized hours of service set as described in #2, above and shall be paid for such services at a rate to be determined upon remand.
- 5) The cost of an average digital speech device of the type described by Dr. Burton shall be determined and paid to the Appellant to defray the cost of the more expensive device. See Record at 115.

Hearing Officer Determination upon Second Remand – November 2013

The second Department Hearing Officer³² held another evidentiary hearing on October 25, 2012 and October 31, 2012 and issued a more thorough Final Order on November 19, 2013. This nearly forty-page Final Order was so detailed, however, that it went well beyond answering the five questions posed by this court in its most recent Order of Remand. The Hearing Officer considered the testimony and evidence from the previous hearing, as well as considering testimony from four Department witnesses: (1) the Director of DDSN HASCI Division, Dr. Linda Veldheer;³³ (2) the Department HASCI Waiver Administrator, Anita Atwood; (3) the Appellant's

³¹ The court held oral arguments, yet again, on March 1, 2010. On June 2, 2011, the parties agreed that the issue of the PASARR evaluation and the payment of the medical expenses incurred in New York would not be addressed in this appeal and consented to reargue the remaining issues on June 23, 2011. This court issued an Order on May 14, 2012, and the Appellant filed a motion for Rehearing on May 24, 2012. The court granted that motion, rescinded its order, and further ordered another hearing on the Motion for Rehearing on July 17, 2012. The court issued its second Order on July 30, 2012.

³² The Hearing Officer, Elizabeth Hutto, noted on page five of her Final Order that the "Hearing Officer who presided over the 2007 and 2009 matters is deceased."

³³ The Hearing Officer noted that the DDSN Director of the HASCI Division, Dr. Veldheer testified at the 2012 hearing that the basis for both denials were erroneous. She testified that in March 2007, HASCI did not have waiver

current Service Coordinator, Ashley Wingo; and (4) Zanipha Mohammed of Department Durable Medical Equipment. The Appellant's testifying witnesses were LPN Rhonda Galus; and Sandra Ray, a speech pathologist. In addition, the Appellant submitted twenty-nine (29) exhibits, along with Declaration Statements from the Appellant, her mother, her father, and Kathy Hoover, RN, as well as affidavits from Lennie Mullis and Don Kovach of Dynavox Mayer-Johnson.

Department's Lack of Medical Evidence

The Hearing Officer focused on the lack of medical evidence the Department presented at both evidentiary hearings. She found that the Department presented no "medical witnesses with direct knowledge of the [Appellant's] medical condition at either of the two hearings in this matter." (R. at 19.)

The Hearing Officer found the Department provided no records evidencing that a Department physician had ever reviewed the Appellant's medical records or assessed her medical needs. (Final Order at 24 and 26.) The Hearing Officer noted that in the 2009 evidentiary hearing before the previous Hearing Officer, the Department's Medical Director, Dr. Marion Burton, testified he had never met the Appellant prior to the 2009 hearing and was only somewhat familiar with her case. Dr. Burton was unaware of any details of the care the Appellant was to receive upon discharge from the hospital, and admitted he had no training in the treatment of head and spinal cord injuries and was only vaguely familiar with the HASCI waiver program. (R. at 19; 2009 Hr'g Tr. at 92-93.) The Hearing Officer noted that in 2009 Dr. Burton testified that he did not have the expertise to override the orders of a treating physician, and that his decision to deny services was based upon Department guidance and the DHHS provider manual policy, and not on any direct knowledge of the Appellant's condition. (R. at 19; 2009 Hr'g Tr. at 109-111.)

Not only was there no Department physician review of the Appellant's condition to determine the hours of skilled nursing services needed by HASCI waiver participants, the HO also

limits, so the earlier March 2007 denial was incorrect. She also testified that the basis listed for the denial on the March 30, 2007 HASCI Denial Form was also erroneous, because "it would be improper for a denial to be based on the individual's service costing more than nursing home care since there are no individual limits." (Final Order at page 8.) The Hearing Officer also noted that neither denial form listed a statutory citation. Though the most recent Hearing Officer's Final Order (dated November 2013) referenced a March 14, 2007, Notice of Denial of HASCI waiver services, the Appellant never mentioned or submitted this denial in June 2007. Therefore, although the Hearing Officer referenced the denial in her Final Order, this court declines to find any meaning in the denial the Appellant never saw fit to mention in her original appeal in 2007. (R. at 9 in Final Order.)

found the evidence showed that, prior to January 2010, "there was no nursing review at the agency to see if participants were getting the services they needed." (R. at 18.) The Hearing Officer found that, under the current nursing hours review process, the Department does not seek the recommendation of the treating doctor regarding nursing hours needed by HASCI waiver participants. The current authorization process for nursing hours requires a centralized DDSN nurse to perform a record review. Though there have been at least two reviews by a DDSN nurse since 2011, according to the testimony of the Appellant's current Service Coordinator, Ms. Wingo, that nurse has never met the Appellant nor been to her home. (Final Order at pp. 16 and 25.)

Dr. Veldheer testified that it was the physician's duty to identify the participant's condition and the specific nursing care required, but that the DDSN centralized nurse determines the number of nursing hours. Dr. Veldheer testified further that when a treating physician ordered nursing hours that "exceeded limits, the centralized nurse would 'not consider it.'" (R. at 19; Tr. at 232.) Additionally, Dr. Veldheer testified that the DDSN process for determining medically necessary nursing hours does not involve a physician, but that it is the "[D]DSN centralized nurse who determines how many nursing hours are needed." (R. at 18.)

Despite having never met the Appellant, the DDSN centralized nurse completed two annual medical record reviews of the Appellant in 2011 and 2012, both of which are included in the record. (Final Order p. 18.) Both reports noted no improvements in condition, as well as the numerous medical conditions and complications that afflict the Appellant.³⁴ In the 2012 nursing report, the DDSN centralized nurse supported a twelve (12) hour increase in nursing hours (from 22 to 32 hours weekly). (Final Order at page 19-20.) The Hearing Officer found that the DDSN centralized nurse's recommendation of an increase in nursing hours in 2012 "seems to indicate that either the [Appellant's] condition has worsened over the past year or that the previous year's 22 nursing hours were inadequate." (R. at 22.)

³⁴ The Appellant introduced three medical record reviews of the DDSN centralized nurse, which "supported the [Appellant] continuing with the ordered 22 nursing hours per week." An August 9, 2011, report noted numerous medical conditions and complications, to include experiencing an abdominal hematoma secondary to Baclofen pump removal (along with acute blood loss); history of constipation; history of pulmonary embolism with subsequent placement of an AV fistula; history of seizures that required hospitalizations and a diagnosis of UTI's which doctors believed contributed to the seizures; hypotension; history of depression/anxiety; tracheostomy; and dysphagia. The Appellant can only shrug her shoulders, has a tracheostomy in place which requires continuous suctioning "several times a day" and trach care "frequently." (tracheoesophageal fistula). She also has a supra-pubic catheter, decubitus ulcers, dysphagia, hypothyroidism, and a history of seizures since 2011. (Final Order at 18.)

RN Nursing Services Never Received

The Hearing Officer also found that evidence in the record reflected that the Appellant had never received RN services.³⁵ The Appellant's first Service Coordinator, January Gosnell, testified at the hearing that she never found an RN in the area willing to work a two (2) hour shift and therefore those care hours went unfilled.³⁶ The Hearing Officer found that in addition to having never received the RN hours she was to receive, the Appellant had not been re-evaluated thirty (30) days after her initial discharge from the hospital to determine whether the fourteen hours per week of RN care should continue. (R. at 25.) To compound the issue, in 2007 the Service Coordinator initially told the Appellant's family that they could not consolidate the RN hours so that an RN could provide services for longer periods of time over fewer days. The Hearing Officer found that the Service Coordinator incorrectly informed the family that it was not possible to combine these nursing hours under the Waiver.³⁷ (R. at 11 and 25.)

The Hearing Officer also found that the only medically trained witness to testify at either evidentiary hearing with direct knowledge of the Appellant's condition was the Appellant's Licensed Practical Nurse (LPN), Ms. Rhonda Galus, who testified extensively concerning the Appellant's complicated and fragile medical state. The Hearing Officer found Ms. Galus' testimony meaningful since she was the only caregiver, aside from the Appellant's mother, who had spent a substantial amount of time with the Appellant. She testified that the Appellant needed to be suctioned throughout the day, because a mucus plug in her tracheostomy tube could be deadly without a nurse or the Appellant's mother present to suction it. (First Hr'g Tr. at 174.) She also testified the Appellant could not be left alone, and that an RN had never been involved in the Appellant's care at home. (R. at 26.)

Ms. Galus further testified the Appellant has frequent bouts of pneumonia and urinary tract infections, along with a history of decubitus ulcers, or bed sores, which required repositioning at

³⁵ Upon discharge on May 9, 2007, the Appellant was unable to find a provider of RN services willing to work the authorized hours per week and thus was unable to fill the position. The inability to locate a suitable RN was due to the Service Coordinators erroneous assertion that the Appellant could only receive RN hour in daily two-hour increments. The Appellant and her family relied on this erroneous assertion. The Appellant still has not received RN hours in her home since her initial discharge from the hospital in 2007.

³⁶ The Hearing Officer found that the Appellant has never received RN care at home, other than sending an RN to the home to periodically supervise the LPN by checking her paperwork, and that this supervision was not part of the Service Plan.

³⁷ At the hearing, both the HASCI Division Director, Ms. Atwood, and the Director of DDSN HASCI waiver services, Dr. Veldheer, testified that waiver participants may combine nursing hours. (Final Order at Page 11.)

least once or twice every two hours. (R. at 17.) The Appellant also takes medications for depression and anxiety, as well as medications to prevent seizures, muscle spasms, bladder spasms, and migraine headaches. She also has kidney stones, which cause the Appellant's catheter to leak, and place her at risk for a break-down of her skin. (R. at 17.) Ms. Galus testified that only a nurse or the Appellant's mother could keep her safe while she was having a grand mal seizure or reinsert her catheter after a seizure. Lastly, the Appellant has difficulties with speaking and being understood and therefore is unable to alert her caregiver when she requires care. "When she does attempt to explain her needs, it is difficult to understand as she speaks in a whisper. This communication barrier can at times delay the Petitioner getting timely care." (R. at 22.)

Ms. Galus testified that an RN could provide services that an LPN cannot, such as drawing and monitoring blood levels; monitoring skin breakdown and decubitus ulcers; performing infection risk assessments; performing lung assessments (due to the Appellant's frequent bouts with pneumonia); and administering IV treatments, among other things. According to the testimony of both parties, the Appellant would have benefitted from a weekly assessment conducted by an RN, but she never received one. According to Ms. Galus, the Appellant choked often and required frequent suctioning, which meant that the Appellant's mother could not leave her unless an LPN was present. Ms. Galus further testified that there is a lack of "substitute coverage or very little coverage on days that [she] is out." (R. at 22.)

The Hearing Officer found that the Appellant's mother, Sandra Waddle, provided all the care that the Department failed to provide. (R. at 25.) The Hearing Officer also found the testimony supported a finding that, in the absence of any RN care and decreased LPN hours, the Appellant's mother had provided the majority of the Appellant's care since her discharge from the hospital in 2007. Ms. Galus testified that with the exception of her mother, the Appellant "does not have good family support to help with her care." (Hr'g Tr. at 172-175.) Shortly after the Appellant's discharge in 2007, her father moved out of the home and the Appellant's mother became the sole family member providing care. (R. at 25.) The Appellant's mother became ill on one occasion and Ms. Galus stayed overnight with the Appellant while off duty as a favor. Ms. Galus recounted that she was unable to sleep because the Appellant required nursing care every two (2) to three (3) hours throughout the night, including suctioning of her tracheostomy tube.

Service Coordinator Omissions or Erroneous Information

The Hearing Officer found that since the Appellant turned eighteen (18) years old on

January 13, 2006, reaching the age of majority, her parents were no longer legally responsible to care for her. (Final Order at p. 32.) The Hearing Officer also found that sometime in 2007 prior to her discharge, the Appellant's DDSN Service Coordinator incorrectly "told the [Appellant's] mother that [D]DSN rules prohibited [BW's] mother from being paid for services she provided to [BW] even though [BW] was an adult at this time. [Therefore,] [BW's] mother should be reimbursed for the number of hours per week that should have been in effect based on continuation of benefits pending the final outcome of the 2007 appeal." (Final Order at p. 32.) The Hearing Officer found that the Appellant's mother provided attendant care services to the Appellant, and that "the parties are in agreement that the current payment rate for attendant care is \$11.10 [per hour]." (Final Order at p. 33.) The Hearing Officer included a payment table indicating how she calculated the hours the Appellant's mother should be compensated (located at page 33 of the Final Order), for a calculated total of \$140,148.60.

In addition to this misinforming [BW]'s mother she could not receive compensation for the care she provided to her adult daughter, the same Service Coordinator erroneously informed the Appellant's family in 2007 that they could not combine the RN hours. During the hearing both the HASCI Division Director, Ms. Atwood, and the Director of DDSN HASCI waiver services, Dr. Veldheer, testified that waiver participants may combine nursing hours. (Final Order at pp. 11 and 25). The Hearing Officer found that the inability to locate a suitable RN was due to the Service Coordinator's erroneous assertion that the Appellant could only receive RN hour in daily 2-hour increments and that the Appellant and her family relied on this erroneous assertion. Lastly, the current Service Coordinator, Ms. Wingo, testified that she was not aware that she had the authority to determine the hours of attendant care that the Appellant was allotted, but opined that the Appellant required twenty-four (24) hours of care per day. However, she also testified that she believed her opinion to be irrelevant. (Final Order at 14, Hr'g Tr at 89.)

HASCI Services Provided during Course of this Appeal and HASCI Waiver Limits.

The Hearing Officer noted that although the subsequent reductions in service hours were not known at the time of the appeal letter in April 2007, "it is reasonable to assume her request to reserve her rights indicated she sought continued benefits in the event of future service reductions." (Final Order at p. 29.) With regard to service reductions, the evidence in the record showed that in July 2008, while the Appellant was still under twenty-one (21) years of age, the Department reduced the LPN hours from fifty-six (56) to thirty-two (32) hours. In July 2009, the nursing hours

were again reduced to twenty-two (22) LPN hours per week. In 2011 the LPN hours went back up to thirty-four (34) hours weekly, and this is the current number of nursing hours the Appellant is receiving (in addition to thirty-six (36) hours of PCA Attendant Care and twelve (12) hours of Respite care per week). (Final Order at 10.) According to the Department witnesses, since the HASCI waiver was renewed in January 2010, the combination of nursing and attendant care hours was not to exceed seventy (70) hours per week (ten [10] hours per day). Prior to 2010, there was a twelve (12) hour per day limit (total of eighty-four (84) hours weekly).³⁸ (R. at 12.)

Dr. Veldheer testified that under the HASCI waiver, nursing hours may be used flexibly throughout the week. Dr. Veldheer also testified that under current waiver limits, the Appellant can receive up to fifty-six (56) hours per week of LPN care. Dr. Veldheer admitted that she was aware that the Appellant had been erroneously informed and believed that the maximum number of LPN hours she could receive per week was thirty-four (34) hours, since she was already receiving thirty-six (36) hours of Attendant Care per week. (R. at 15.) Dr. Veldheer also admitted that she had never clarified to the Appellant that attendant hours could be combined to suit the Appellant, or that “nursing hours and attendant hours could be combined in a suitable way for the Waiver participant within the limits.” (R. at 16.)

EPSDT Finding and Nursing Hours

The Hearing Officer found that while under the age of twenty-one (21), the Appellant was entitled to the protections and entitlements of the EPSDT Program and should not have been subject to waiver limits for skilled care services. Specifically, she found that the Appellant was entitled to the protections EPSDT afforded:

...including deference to the orders of her treating physician regarding medically necessary services while recognizing the Respondent can impose reasonable limits on the treating physician’s orders...the initial order of the treating physician was issued during the [Appellant’s] lengthy hospital stay and was supported by a treating physician’s order two years later. The [Appellant] offered into evidence contemporaneous orders and affidavits from her treating physicians stating that 28 hours per week of RN services were medically necessary. The testimony provided by the Respondent’s Medical Director showed a lack of first-hand knowledge of the [Appellant’s] medical needs. The recommendations of the Respondent’s physician

³⁸ The Hearing Officer found there was no evidence in the record of this service change in nursing hours, that Dr. Veldheer testified that at that time, HASCI limits were sixty (60) hours per week of LPN care or forty-five (45) hours or RN care per week or a combination not to exceed \$1,425 based on an LPN rate of \$23.75 per hour or an RN rate of \$31.35 per hour. (R. at 11). According to Ms. Atwood’s testimony, on the other hand, there were “no limits on nursing services or attendant care prior to July 2008.” (Id.)

were based on the [Appellant] receiving 50 hours of nursing care per week (an amount which she had not received since 2008) along with the assumption that both parents were providing supporting care to the [Appellant]. The Respondent has not provided any record of a medical examination of the [Appellant's] needs 30 days after her discharge from the hospital. Nor did the Respondent provide any record of a medical examination at the 2009 or the 2012 hearings. It appears that the Respondent has not conducted a medical examination of the Petitioner at any time during the pendency of this appeal. The [Appellant] should not have been subject to Waiver limits for skilled care services while under the age of 21 and should have received 28 hours of RN and 84 hours per week of LPN as ordered by her treating physician. *These hours should have continued through the final result of the appeal.* (emphasis added). (R. pp. 32-33.)

In sum, the Hearing Officer found that the Appellant has been maintained at home by the extraordinary efforts and dedication of her mother, without many services that she was entitled to receive. (R. at 27). She further found that due to the Appellant's medical conditions and her dependence on a single caregiver, she should receive the maximum services available under the HASCI waiver. The Hearing Officer found that the "current waiver limits are 45 hours per week of RN or 60 hours a week of LPN or some combination not to exceed \$1,425 per week." (Id.) She also found that the Appellant would have benefitted from fourteen (14) hours of RN a week through June 2007, and the Appellant's benefits should have continued at the levels ordered by her treating physician during the pendency of this appeal.

ISSUES ON APPEAL

1. Has the Department violated the Reasonable Promptness Mandate of the Medicaid Act contained in 42 U.S.C. § 1396(a)(8) by failing to provide medically necessary services and equipment with reasonable promptness in the amount, duration and scope necessary to meet the goal of providing services in the least restrictive setting?
2. Has the Department violated the South Carolina Administrative Procedures Act by limiting and reducing Medicaid Services provided to the Appellant based on binding norms that were established by the state agencies without promulgation of regulation?
3. Has the Department violated the Appellant's right to due process by failing to provide notices meeting the explicit requirements of 42 C.F.R. 431.210 and failing to provide an evidentiary hearing followed by a final decision within ninety (90) days of her appeal?
4. Has the Department violated the requirements of the ADA and the Integration Mandate set forth in *Olmstead v. L.C.* by: 1) failing to provide services in the least restrictive environment; 2) failing to give the greatest deference to the opinions of the treating physician; and 3) failing to find that the state did not meet its burden of proving that providing services ordered by the Appellant's physician would fundamentally alter the state's system?

5. Did the Hearing Officer err in determining the amount due the Appellant's mother for services provided since her discharge from the hospital in 2007 and for the speech device ordered by her physicians?
6. Did the Hearing Officer err in determining that when a denial of services is appealed, that the denied services must continue until a decision is rendered on the appeal?
7. Did the Hearing Officer err in determining the amount of services that should be used in calculating the reimbursement for the care rendered to the Appellant by her mother, had she requested it?

STANDARD OF REVIEW

The ALC hears appeals from decisions of the Department pursuant to the Administrative Procedures Act (APA). S.C. Code Ann. § 44-6-190 (2002 & Supp. 2013); *Estate of Nicholson ex rel. Nicholson v. S.C. Dep't of Health and Human Servs.*, 377 S.C. 590, 660 S.E.2d 303 (Ct. App. 2008). Accordingly, the APA's standard of review as set forth in § 1-23-380 governs these appeals. See S.C. Code Ann. § 1-23-600(D) (Supp. 2013). That section states:

The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

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

S.C. Code Ann. § 1-23-380(5) (Supp. 2013).

A decision is supported by substantial evidence when the record as a whole allows reasonable minds to reach the same conclusion as the agency. *Friends of the Earth v. Pub. Serv. Comm'n of S.C.*, 387 S.C. 360, 366, 692 S.E.2d 910, 913 (2010). "When determining whether the record contains substantial evidence to support an administrative agency's findings the court cannot substitute its judgment on the weight of the evidence for that of the agency." *S.C. Dept' of Mental Health v. Moore*, 295 S.C. 42, 45, 367 S.E. 2d 27, 28 (1988). "The findings of the agency

are presumed correct and will be set aside only if unsupported by substantial evidence.” *Hull v. Spartanburg County Assessor*, 372 S.C. 420, 424, 341 S.E.2d 909, 911 (Ct. App. 2007) (citing *Kearse v. State Health and Human Servs. Fin. Comm’n*, 318 S.C. 198, 200, 456 S.E.2d 892, 893 (1995)). Accordingly, “[t]he ‘possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency’s finding from being supported by substantial evidence.’” *Grant v. S.C. Coastal Council*, 319 S.C. 348, 461 S.E.2d 388 (1995) (citing *Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm’n*, 282 S.C. 430, 432, 319 S.E.2d 695, 696 (1984)). In applying the substantial evidence rule, “a reviewing court will not overturn a finding of fact by an administrative agency ‘unless there is no reasonable probability that the facts could be as related by a witness upon whose testimony the finding was based.’” *Sea Pines Ass’n for Prot. of Wildlife, Inc. v. S.C. Dep’t of Natural Res.*, 345 S.C. 594, 603-04, 550 S.E.2d 287, 292 (2001) (quoting *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 136, 276 S.E.2d 304, 307 (1981)).

Further, an abuse of discretion occurs when an administrative agency’s ruling is based upon an error of law, such as application of the wrong legal principle; or, when based upon factual conclusions, the ruling is without evidentiary support; or, when the trial court is vested with discretion, but the ruling reveals no discretion was exercised; or, when the ruling does not fall within the range of permissible decisions applicable in a particular case, such that it may be deemed arbitrary and capricious. *State v. Allen*, 370 S.C. 88, 94, 634 S.E.2d 653, 656 (2006) (application of standard to circuit court) (citing *Fontaine v. Peitz*, 291 S.C. 536, 539, 354 S.E.2d 565, 566 (1987)); see also *Converse Power Corp.*, 350 S.C. 39, 47 564 S.E.2d 341, 345 (Ct. App. 2002) (quoting *Deese v. State Bd. of Dentistry*, 286 S.C. 182, 184-85, 332 S.E.2d 539, 541 (Ct. App. 1985) (“A decision is arbitrary if it is without a rational basis, is based alone on one’s will and not upon any course of reasoning and exercise of judgment, is made at pleasure, without adequate determining principles, or is governed by no fixed rules or standards.”)).

South Carolina courts have noted the deferential standard employed in the review of the Department’s decisions given the Department’s extensive specialized knowledge of its own regulations. “[B]ecause the [Department] has been designated as the single state agency for implementation of Medicaid, great deference must be accorded interpretations by the agency of Medicaid laws and regulations.” *Hampton Nursing Ctr. v. State Health & Human Servs. Fin. Comm’n*, 303 S.C. 143, 147, 399 S.E. 2d 434, 436 (Ct. App. 1990); *S.C. Police Officers Retirement Sys. V. City of Spartanburg*, 301 S.C. 188, 391 S.E. 2d 239 (1990); *Doe v. S.C. Dep’t of Health &*

Human Servs., 398 S.C. 62, 80, 727 S.E. 2d 605, 614 (2011); *Byerly Hosp. v. S.C. State Health and Human Servs. Fin. Comm'n*, 319 S.C. 225, 460 S.E. 2d 383 (1995) (great deference is given to an agency's interpretation of regulations where it has particular expertise).

DISCUSSION

As an initial matter, one question that this court must also address is whether the Appellant's letter of May 9, 2007, accepting services with reservations, gave the Appellant carte blanche to have this court address every issue that might arise during the course of the appeal, without having to go through the processes required under the Administrative Procedures Act. This court dismisses that assumption, because to allow the Appellant this much latitude would confound these proceedings and allow for the obfuscation of the issues throughout the course of time. As in the present case where over the past ten (10) years the Appellant's issues have metamorphized into a nearly unrecognizable morass, given the twists and turns of the appellate issues. Accordingly, as set forth with particularity infra, a number of the issues raised by the Appellant are not properly before this court.

1. Has Respondent violated the Reasonable Promptness Mandate of the Medicaid Act contained in 42 U.S.C. § 1396(a)(8) by failing to provide medically necessary services and equipment with reasonable promptness in the amount, duration and scope necessary to meet the goal of providing services in the least restrictive setting?

This issue was not raised to nor ruled on by the Hearing Officer, and, therefore this issue has not been preserved for appellate review. "Issues not raised to and ruled on by the agency are not preserved for judicial consideration." *Brown v. South Carolina Dep't of Health and Environmental Control*, 348 S.C. 507, 519, 560 S.E.2d 410, 417 (2002). If an issue is raised to, but not ruled on by the agency, the Administrative Procedures Act recognizes a party's right to seek reconsideration of a final agency decision or to request a rehearing. *Kiawah Resort Assoc. v. South Carolina Tax Comm'n*, 318 S.C. 502, 506, 458 S.E.2d 542, 544 (1995). This was not an issue that was addressed in the HO's Final Order.³⁹ Further, the Hearing Officer clarified and

³⁹ One of the captions in the Appellant's Pre-Hearing Brief is "Has Respondent violated the due process, reasonable standards, amount, duration and scope and other state and federal requirements by not providing, with reasonable promptness, the LPN, personal care attendant services, adult companion service, psychological services, physical therapy, occupational therapy, speech and language services and other services determined by B.W.'s treating physicians to be medically necessary, taking into consideration the absence of any legal obligation of B.W.'s family to provide her care." Although, it seems that the Appellant may have attempted to argue this issue in her Pre-Hearing Brief, it was not addressed by the Hearing Officer.

unequivocally stated in her Final Order that “[a]ny issues not addressed in the Order are deemed dismissed.” (Final Order p. 39.) The Appellant declined to request reconsideration or a rehearing and failed to respond to the Department’s Motion for Reconsideration filed on December 2, 2013.

2. Has the Department violated the S.C. Administrative Procedures Act by limiting and reducing Medicaid Services provided the Appellant based on binding norms that were established by the state agencies without promulgation of regulation?

The Hearing Officer found that DHHS “violated [BW’s] due process rights in enforcing its waiver reductions against her during the pending appeal. Because of the due process violations, it is unnecessary to determine whether the [Department] has given agency rules the weight of a promulgated regulation when the reductions were applied.” (R. at 32.) The Appellant first filed her appeal in April 2007, after which her HASCI waiver services were reduced during the pendency of that appeal. However, the Appellant did not file another appeal after these reductions occurred, and therefore, is now foreclosed from challenging those reductions. Even if the court were to find that the Appellant timely filed an appeal on the reduction of services, the Appellant is incorrect in asserting that the state must promulgate regulations in order to limit or reduce waiver services.

This specific issue has been dispositively decided by the courts in South Carolina. In *Stogsdill v. South Carolina Department of Health and Human Services*, 410 S.C. 273, 763 S.E. 2d 638 (2014), the Court held that “based on the relevant statutory scheme and federal/state nature of Medicaid and the Waiver, DDSN was not required to pass a regulation to enact the cap as an enforceable provision.” Reiterating the South Carolina Supreme Court’s decision that federally approved waiver provisions carry the force and effect of law, and as a result, it is “unnecessary for such provisions to be promulgated as state regulations to be enforceable.” *Doe v. South Carolina Department of Health & Human Services*, 398 S.C. 62, 727 S.E. 2d 605 (2011). Additionally, the Court of Appeals again held in 2016 that “[b]ecause CMS approved South Carolina’s waiver plan, the terms of the waiver program carried the force and effect of federal law and were not required to be promulgated as regulations under the state’s APA.” *Myers* at 308 (quoting *Stogsdill*, 410 S.C. at 277, 763 S.E. 2d at 640). Therefore, this court also concludes that approval by state regulation was not required to give the Waiver’s provisions the force and effect of law.

3. Has the Department violated the Appellant's right to due process by failing to provide notices meeting the explicit requirements of 42 C.F.R. 431.210 and failing to provide an evidentiary hearing followed by a final decision within ninety (90) days of her appeal?

Notice Requirement and Due Process and Hearing Officer Authority under Remand Order. The mandate of an appellate court is jurisdictional and "a trial court has a duty to follow the appellate court's directions." *Ackerman v. McMillan*, 324 S.C. 440, 443, 477 S.E. 2d 267, 268 (Ct. App. 1996). When this court remands a case, the agency "only has the jurisdiction and authority mandated by this court." This court finds that the second Hearing Officer erred when she broadened the parameters of the court's 2012 remand order, and went further and determined that the Department violated the Appellant's due process rights in 1) failing to list the "statutes or regulations the actions were based upon" or "provide instruction on how to appeal the negative action"; and 2) that the reductions in services that occurred during the course of this appeal, from 2008 through 2012, were improper because they were "without notice and the opportunity to appeal." (Final Order at 30.)

The Appellant argues that her due process rights were violated because the Department's original denial notices failed to comply with 42 C.F.R. § 431.210(b), which required the Department to inform the Appellant of "the reason for the intended action." As noted by the Department, the Appellant did not preserve this issue for appellate review:

Appellants appear to challenge the Department's failure to provide adequate written notice of the reduction in services pursuant to the waiver renewal as required under 42 C.F.R. § 431.210. However, I find this ground on appeal has not been preserved for appellate review. Appellants refer to this alleged violation within the "Facts" section of the brief. Appellants do not include this issue as a separate ground on appeal and there is no reference or citation to any legal authority contained within the discussion section of their brief. Thus, I conclude that this ground on appeal has been abandoned. *Glasscock, Inc.*, 348 S.C. at 81, 557 S.E.2d at 691.

Nevertheless, even if it could be construed that the Appellant adequately preserved these issues on appeal, the Appellant's argument must fail. "Generally, due process is flexible and calls for such procedural protections as the particular situation demands." *Leventis v. S.C. Dep't of Health and Env'tl. Control*, 340 S.C. 118, 131, 530 S.E.2d 643, 650 (Ct. App. 2000) (citing *Ogburn-*

Matthews v. Loblolly Partners, 332 S.C. 551, 561, 505 S.E.2d 598, 603 (Ct. App. 1998))(internal quotation marks omitted.) “Any party in an administrative agency proceeding is entitled to certain procedural opportunities of notice and a fair hearing.” *Palmetto Alliance, Inc. v. S.C. Pub. Serv. Comm’n*, 282 S.C. 430, 435, 319 S.E.2d 695, 698 (1984). “The requirements of due process include notice, an opportunity to be heard in a meaningful way, and judicial review.” *Leventis*, 340 S.C. at 131, 530 S.E.2d at 650 (citing *Ogburn-Matthews*))(internal quotation marks omitted.) Further, “proof of a denial of due process in an administrative proceeding requires a showing of substantial prejudice.” *Palmetto Alliance, Inc.*, 282 S.C. at 435, 319 S.E.2d at 698; *see also Leventis*, 340 S.C. at 131-32, 530 S.E.2d at 650.

Although due process is a flexible concept, federal regulations provide specific requirements regarding the notice requirements for state-level Medicaid hearings. The procedures for appealing a decision regarding Medicaid services provided under the Waiver program are set forth in 42 C.F.R. §§ 441.200 *et seq.* Those regulations provide that a state-level hearing for Medicaid recipients under a state waiver “must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970).” 42 C.F.R. § 431.205(d). The state agency must grant an opportunity for a hearing to any applicant who requests it because his claim for services is denied, or if the state agency acts to suspend, terminate or reduce services. 42 C.F.R. § 431.220(a)(1); 42 C.F.R. § 431.200(b). The agency is required to provide notice of the fair hearing, which must contain specific information:

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

(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

42 C.F.R. § 431.210. As the state agency administering the Medicaid program, the Department must comply with all federal Medicaid laws and regulations. *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Doe v. Kidd*, 501 F.3d 348, 351 (4th Cir. 2007).

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

The Appellant asserts that her due process rights were violated because she did not receive adequate notice of the reduction in services. This same notice issue was addressed in *Stogsdill*, where the Court found that, although the Department of Disability and Special Need's (DDSN) notice of reduction in services failed to comply with 42 C.F.R. § 431.210, because the record demonstrated that the Appellant had fully exercised his opportunity for a hearing and judicial review, he could not establish that he was substantially prejudiced. *Stogsdill*, 410 S.C. at 281-82, 763 S.E. at 644. Similarly, here the record demonstrates that the Appellant has fully exercised her opportunity for a hearing and judicial review. The Appellant has been represented by the same experienced counsel throughout this matter, including two evidentiary hearings and three appeals involving the same issues. She initially failed to comply with the Hearing Officer's interlocutory order in 2007 and the Hearing Officer properly dismissed the matter. In 2009, the Appellant availed herself of an evidentiary hearing in which she presented live testimony and affidavits, along with numerous exhibits. The same holds true for the 2012 evidentiary hearing. The Department's failure to technically comply with the notice, alone, does not constitute a due process violation when the Appellant has failed to show that she was substantially prejudiced by the Department's HASCI denial notice from March 2007. Therefore, the court declines to find that the Appellant's due process rights were violated by the notices she received.

The Appellant has not shown how the process, or a fair hearing would have been conducted differently had the notices complied with the technical requirements of 42 C.F.R. § 431.210. As such, the Appellant has simply failed to provide any evidence to the court of how she was prejudiced by the lack of technical compliance with 42 C.F.R. § 431.210. *See Kocher v. Dep't of Health and Human Serv. of State of Wis.*, 152 Wis.2d 170, 179-80, 448 N.W.2d 8, 12 (Wis. App. 1989) (finding that Medicaid service recipient was not prejudiced by inadequate notice and was provided with an "effective opportunity to defend" the Department's termination action where a "case summary" was sent to Appellant's attorney prior to the termination hearing, "elaborat[ing] the nature and reasons for the termination action"); *see also Hopkins v. Dep't of Human Services*, 802 A.2d 999 (Me. 2002) (holding, in a termination of Medicaid benefits action, that Appellants were unable to show substantial prejudice where the Department failed to meet the technical notice requirements of 42 C.F.R. § 431.210). Therefore, with regard to the Department's failure to list the statute and hearing rights in the HASCI Waiver denial notice of 2007, this court also finds that the Department's non-compliance with the requirements set forth in 42 C.F.R. § 431.210 did not constitute a denial of due process per se, and that the Appellant failed to carry the burden of showing that she was substantially prejudiced because of this failure.

Furthermore, because the Appellant has not demonstrated substantial prejudice resulting from the hearing notices provided by the Department, the court finds that the Hearing Officer overstepped the bounds of the remand and erred in her conclusion that the Appellant's due process rights were violated in the hearing notices. It is the Appellant who bears the burden of a record on appeal sufficient for intelligent review. Rule 210(h), SCACR. Moreover, an appellate court "will not consider any fact which does not appear in the Record on Appeal." *See Bonaparte v. Floyd*, 291 S.C. 427, 444, 354 S.E. 2d 40, 50 (St. App. 1987.)

In this case, this court never addressed the notice issue in either of its remand orders from 2009 or 2012, and the first Hearing Officer never addressed the notice issue in either the dismissal order or the Final Order. ALC Rule 37(B) provides that "the statement of issues on appeal shall be concise and direct as to each issue and may be stated in question form. Broad general statements may be disregarded by the Court." As the Supreme Court held in *Jones v. Lott*, 387 S.C. 339, 346, 692 S.E. 2d 900, 903 (2010), "[e]very ground of appeal ought to be so distinctly stated that the reviewing court may at once see the point which it is called upon to decide without having to 'grope in the dark' to ascertain the precise point at issue." Discussion of these later reductions in

service is an obvious departure from the questions the court has asked the Department to address in both of its remand orders.

Although this court has never explicitly determined the appropriateness of the Hearing Officer's original dismissal in November 2007, this court finds it necessary to address this question in light of the Appellant's second due process argument. On March 2, 2009, this court issued an Order of Remand without ruling on the appropriateness of the Hearing Officer's dismissal. Rather than affirm that dismissal, the court chose to remand the case for an evidentiary hearing and found that the "[s]ignificant impasse seems to have been the [Appellant's] failure to produce a 'Memorandum of Understanding' as requested by the Hearing Officer."⁴⁰ (R. at 1692.) The ALC held that "it is in the interest of judicial economy that this case proceed on its merits, without assessment of blame, by Appellant providing the information described below to the Respondent, the Hearing Officer and this Court." *Id.* Though the ALC did not explicitly assign "blame," this court clearly recognized the Appellant's failure to comply with the Hearing Officer's interlocutory order to provide specific, requested information that would have assisted the Hearing Officer in deciding the issues on appeal. The Hearing Officer had attempted to require the Appellant to bring into focus the precise nature of the alleged errors, to no avail.

Additionally, regulation 42 C.F.R. §431.244(f)(1) instructs that "the agency must take final administrative action *ordinarily* within 90 days of the request for a fair hearing." The first HO aptly noted in her original letter to the parties on June 11, 2007, however, that the Appellant's April 28, 2007 appeal "did not present an *ordinary* appeal." The language in the pertinent regulation is to provide guidance but is not an absolute mandate that a hearing must occur within ninety (90) days, and this court now finds that it was the Appellant's own failure to comply with the Hearing Officer's seemingly simple orders that caused the initial delays and ultimate dismissal on procedural grounds in September 2007.

With this in mind, this court finds that the original Hearing Officer did not abuse her discretion in dismissing the appeal on procedural grounds in September 2007. For hearings regarding the Medicaid program, federal regulations provide the agency may deny or dismiss a hearing request if the applicant withdraws the request in writing or the applicant fails to appear at

⁴⁰ The Honorable John D. McLeod, formerly of this court, held a hearing in this matter on January 14, 2009, and in preparation for issuing the Order, asked the Department to identify the remaining issues based on the Appellant's April 28, 2007, letter of appeal.

a scheduled hearing without good cause. 42 C.F.R. § 431.223. The Department has promulgated state regulations concerning the conduct of fair hearings, which instill broad authority in hearing officers. Specifically, regulation 126-154 states:

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

27 S.C. Ann. Regs. 126-154 (1976).

The Appellant argues that the federal regulations provided the exclusive authority for the conduct of Medicaid-related hearings, and that, pursuant to 42 C.F.R. §431.223, a Hearing Officer may dismiss a matter only if the applicant withdraws her request for a hearing or fails to appear at her hearing without good cause. Moreover, the Appellant contends that the federal law preempts any state regulations and that since neither of these events took place, the Hearing Officer had no authority to dismiss the Appellant's appeal in 2007. This court disagrees.

As stated earlier, the federal regulation provides two grounds in which an agency may dismiss an appeal. Further, the federal regulation is not so comprehensive that it preempts the state from passing regulations which are not contradictory. In this case, the state has promulgated regulations that provided additional grounds for dismissal and can be applied harmoniously with the federal regulations. See *State v. 192 Coin-Operated Video Game Machines*, 338 S.C. 176, 187, 525 S.E. 2d 872, 877 (2000). Likewise, the language of 42 C.F.R. § 431.223 and 27 S.C. Code Ann. Regs. 126-154 do not contradict each other. *Mims v. S.C. Dep't. of Health and Human Services*, Docket No. 07-ALJ-08-0082-AP.

Additionally, Regulation 126-156 provides that a Hearing Officer "may direct the parties in any appeal to meet prior to a formal hearing for the purpose of narrowing the issues and exploring the possibilities of settlement of matters in contest." 27 S.C. Ann. Regs. 126-156 (1976). Therefore, the HO's decision to require a Prehearing Conference was because "the nature of the controversy in this matter is unclear." (R. at 3254.) The Hearing Officer explained that the pre-hearing conference was "necessary for purposes of simplifying the issues, expediting the hearing process and affording parties an opportunity to participate in the disposition of the appeal and for identification of justiciable issues." (Id.)

In this case, the Hearing Officer not only required a prehearing conference, but also required the Appellant to complete the extra step of synopsisizing the issues on appeal for each party and synopsisizing the relative positions and then getting the Department's approval of that MOU "as to form and substance." The Hearing Officer was not requiring the parties to agree on the outcome, but only on what each side believed the issues were, in order to clarify the issues on appeal. Additionally, though the Hearing Officer did not define for the parties what this meant, this court finds that a reasonable person would conclude that this extra step required that the Appellant send a draft of the MOU to the Department prior to faxing it to the Hearing Officer. However, rather than faxing a draft MOU to the Department, the Appellant faxed the MOU directly to the Hearing Officer on the day it was due. In short, despite being ordered to do so, the Appellant inexplicably never managed to complete this innocuous requirement. The Appellant, through counsel, rather than simply comply, wrote to the Hearing Officer that being asked to do this could be likened to Hercules being "ordered...to slay Hydra, a nine-headed swamp creature. Requiring [Appellant's] counsel to go into the Congaree Swamp to find and slay such a creature would be a more manageable task than obtaining Respondent's approval of a 'Memorandum of Understanding' in just six working days." (R. at 1749.)

Though this court does not doubt that the Appellant's counsel put forth great efforts for her client, this failure to follow such simple instructions from the Hearing Officer is troubling. Additionally, the Appellant also failed to send the Hearing Officer further documentation that involved denials of services, and simply demanded that she be given a hearing. While with the benefit of hindsight it now appears clear that the most expeditious decision the Hearing Officer could have made was to hold an evidentiary hearing, this court finds that the Hearing Officer's decision to dismiss the appeal on procedural grounds was not arbitrary and capricious or an abuse of discretion, or otherwise violative of Section 1-23-380(A)(5).

4. Has the Respondent violated the requirements of the Americans with Disabilities Act and the Integration Mandate set forth in *Olmstead v. L.C.* by 1) failing to provide services in the least restrictive environment; 2) failing to give the greatest deference to the opinions of the treating physician; and 3) failing to find that the state did not meet its burden of proving that providing services ordered by the Appellant's physician would fundamentally alter the state's system?

As this argument was neither discussed, addressed nor ruled upon in the Final Order, it is not preserved for appellate review. "Issues not raised to and ruled upon by the agency are not preserved for judicial consideration." *Brown v. S.C. Dep't of Health & Envtl. Control*, 348 S.C. 507, 519, 560 S.E. 2d 410, 417 (2002); *Carson v. S.C. Dep't of Natural Res.*, 371 S.C. 114, 120, 638 S.E. 2d 45, 48 (2002) (stating that a court sitting in an appellate capacity may not consider issues not raised or ruled on by administrative agency); *see also Kiawah Resort Assoc. v. South Carolina Tax Comm'n*, 318 S.C. 502, 458 S.E. 2d 542 (1995). If an issue is raised to, but not ruled upon by the agency, nothing in the South Carolina APA prevents a party from seeking reconsideration or requesting a hearing. *Id. at 506*, citing S.C. Code Ann. § 1-23-380 ("proceedings for review are instituted by serving and filing notice of appeal...within thirty days after the final decision of the agency or, if a rehearing is requested, within thirty days after the decision is rendered.") Here, however, the Appellant did not file a Motion for Reconsideration requesting a ruling on the argument, assuming arguendo it was raised. *CF Elam v. S. Carolina Dept of Transp*, 361 S.C. 9, 24, 602 S.E.2d 772, 780 (2004) (Stating a party must file a Rule 59(e), SCRCPP, Motion to Alter or Amend when an issue or argument has been raised, but not ruled on, in order to preserve it for appellate review).

5. Did the Hearing Officer err in determining the amount due the Appellant's mother for services provided since her discharge from the hospital in 2007 and for the speech device ordered by her physicians?⁴¹

Hearing Officer Erred in 2009 Final Order Concerning EPSDT Eligibility

While under the age of twenty (21), the Appellant was entitled to the protections and entitlements of the EPSDT Program. This court finds that the second Hearing Officer's findings concerning the Appellant's entitlement to EPSDT services was supported by substantial evidence, and that the first Hearing Officer erred when she made a contradictory finding in July 2009. The first Hearing Officer summarily concluded in her brief Final Order that the Appellant "did not establish that EPSDT was appropriate." (R. at 3343.) The Hearing Officer referenced no evidence upon which she based this decision and provided no other details or discussion on the question. The 2009 Hearing Officer's finding that the Appellant was not entitled to EPSDT services in 2007 at the time of her discharge when she was nineteen (19) years of age constituted an error of law

⁴¹ This issue, as well as Issue 7, were appealed by both the Appellant and the Department.

and was without evidentiary support. *See Allen*, 370 S.C. at 94. As discussed supra, the EPSDT program is a comprehensive health benefit for all Medicaid-eligible and youth under age twenty-one (21). As such, prior to January 14, 2009, the Appellant would have been eligible for EPSDT services simply due to her age and her Medicaid eligibility. As the Department's second Hearing Officer correctly noted, the EPSDT program covers the broadest possible array of Medicaid services. *See CMS*, U.S. Dep't of Health & Human Servs., Pub. No. 45, State Medicaid Manual; 42 U.S.C. § 1396d(a)(4)(B) & (r).

States are required to cover all treatment services (including both mandatory and optional services) listed in the Medicaid Statute, which includes private duty nursing services, personal care services, medical supplies and equipment, along with "other diagnostic, screening, preventive and rehabilitative services...and restoration of an individual to the best possible functional level." 42 U.S.C. § 1396d(a) (13). Under EPSDT, federal regulations specify that the state has the option to provide required private duty nursing services for recipients under age twenty-one (21) in a home, hospital or skilled nursing facility. Such nursing services are available to recipients, such as the Appellant, who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.

These services can be provided:

- (a) By a registered nurse or a licensed practical nurse;
- (b) Under the direction of the recipient's physician; and
- (c) To a recipient in one or more of the following locations at the option of the State—
 - (1) His or her own home;
 - (2) A hospital; or
 - (3) A skilled nursing facility.

42 C.F.R. § 440.80.

In addition, federal regulation allows a state's Medicaid agency "to establish the amount, duration and scope of services provided under the EPSDT benefit" as long as (1) any limitations imposed are reasonable; (2) the EPSDT service is sufficient to achieve its purpose; and (3) the state's definition of the service comports with the statutory requirement that the state provide all services "that are medically necessary to ameliorate or correct ...conditions discovered by the screening services." 42 C.F.R. § 440.230.

Moreover, Medicaid eligible participants and their families should be informed and made aware of the services available under the EPSDT program. To this end, federal regulations require the agency to “[p]rovide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program.” 42 C.F.R. § 441.56(a). The agency must use “clear and nontechnical language” about the “services available under the EPSDT program and where and how to obtain those services.” 42 C.F.R. § 441.56(a)(2)(ii).

Waiver programs provide for coverage of services that are not otherwise available through the Medicaid program (including EPSDT) because they do not fit into one of the categories listed in section 1905(a). In general:

This includes habilitative services, respite services, or other services approved by CMS that can help prevent institutionalization. These programs are sometimes called 1915(c) waivers after the section of the Social Security Act that authorizes them.

Children under age 21 who are enrolled in an HCBS waiver program are also entitled to all EPSDT screening, diagnostic, and treatment services. Because HCBS waivers can provide services not otherwise covered under Medicaid, waivers and EPSDT can be used together to provide a comprehensive benefit for children with disabilities who would otherwise need the level of care provided in an institutional setting. This enables those children to remain in their homes and communities while receiving medically necessary services and supports. The HCBS waiver services essentially “wrap-around” the EPSDT benefit. If a child enrolled in Medicaid is on a waiting list for HCBS waiver services, EPSDT requirements apply and necessary services that fit into the categories listed in 1905(a) must be covered.

BB 18.2.3.

The genesis of this appeal in 2007, then, concerned the Medicaid and state services the Appellant should have received under the HASCI waiver program as well as the EPSDT Program.⁴² Though she had only received a HASCI denial form on March 30, 2007, and no “official” written denial of EPSDT services, this did not preclude her from receiving services under EPSDT program. At the time of the appeal in 2007, the Appellant was to receive HCBS waiver services under HASCI but was also entitled to services under the EPSDT program. S.C. Code

⁴² Though the Appellant has not been eligible for EPSDT services since January 2009, this program was very relevant at the time the Appellant filed her appeal with the Department in April 2007.

Ann. §§ 44-38-370 and 44-6-30. Under HCBS waiver programs, the state must make several assurances to CMS, to include ensuring that individuals are informed of all reasonable alternatives available under the waiver. The feasible alternatives provision of the Medicaid Act requires states to inform the legal representative of waiver participants of the feasible alternatives under the waiver program and give the choice of either institutional or home and community-based services when the participant is determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility. 42 U.S.C. § 1396n(c)(2)(C). By definition, the entire purpose of the state waiver program is to avoid institutionalization by providing services in home and community-based settings that otherwise would have to be provided in an institution.

Though neither the Department nor the Appellant mentioned or requested private duty nursing services for the Appellant, this did not mean that the Appellant would not have been entitled to those services prior to turning twenty-one (21), while she was still eligible for EPSDT services. This court notes that the difference in nursing hours approved (70 hours) under the HASCI Waiver and those that were ordered by the Appellant's treating physicians, (112 hours), was a difference of forty-two (42) hours of nursing services weekly until January 14, 2009, when the Appellant turned twenty-one (21) years of age.

Likewise, contrary to what the Department has argued, it was not for the Appellant to specifically request a service and then receive an official denial from the agency before she could appeal a denial of EPSDT services. In fact, the record reflects several letters and emails from the Appellant's counsel informing the Department of the Appellant's age, her fragile medical condition, and requesting such services for the Appellant and her family, who sought to care for her in their home under the HASCI waiver program. In her appeal letter of April 28, 2007, the letter referenced a denial of HASCI waiver services as one ground, but it also listed a denial of EPSDT services.

This court also finds that there is substantial evidence in the record to support the Hearing Officer's finding that the Appellant's Service Coordinator, in 2007, failed to inform the Appellant and her family about EPSDT services available to her as a Medicaid eligible participant under the age of twenty-one (21). Although she was coordinating services under the HASCI waiver, the Appellant's Service Coordinator failed to inform the Appellant or her family of the broad range of services allowed under the EPSDT program and the Appellant's eligibility for such services. At the time of the appeal, the Appellant was nineteen (19) years old and would have been eligible for

Children's Personal Care Services and Children's Private Duty Nursing Services through the Medicaid Plan, which would not have been funded through the HASCI waiver. Moreover, as previously discussed, the Hearing Officer relied heavily on *Moore* in analyzing EPSDT services due the Appellant. In *Moore*, the Eleventh Circuit Court of Appeals emphasized that EPSDT services are a federal mandate and are designed to "assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly." *Moore v. Reese*, 637 F. 3d 1220 (11th Cir. 2011.)

In short, there is no dispute that the Appellant, prior to age twenty-one (21), was entitled to Children's Personal Care Services and Children's Private Duty Nursing Services through the state Medicaid plan and EPSDT. Therefore, because nursing services provided to the Appellant prior to the age of twenty-one (21) would not have been funded through the HASCI waiver and subject to those waiver limitations, this court finds it unnecessary to remand the case to the hearing officer to consider that issue again. Though it is impossible for the agency to provide services retroactively, it may be possible for the agency to provide some recompense to the mother for the services she provided her daughter in the absence of the required hours of nursing services prior to turning twenty-one (21).

Specifically, the Hearing Officer found that the Appellant's mother should be reimbursed for the number of hours per week of attendant care services that she had provided out of the hours per week that the Appellant's physician had prescribed, and that these services should have ultimately been provided even throughout the pendency of the 2007 appeal. (Final Order at p. 32.) The Hearing Officer found that the Appellant's mother provided attendant care services to the Appellant, and that "the parties are in agreement that the current payment rate for attendant care is \$11.10 [per hour]." (Final Order at p. 33.) Using calculations generated from a table of payment the HO included in her order, the HO concluded that the Appellant's mother should be compensated a total of \$140,148.60 for the care she provided.

The Appellant appealed this decision and argues that rather than using the one hundred twelve (112) hours per week of care her physicians prescribed to calculate the compensation due to the Appellant's mother, the HO should have used one hundred sixty-eight (168) hours per week as prescribed by the Appellant's physician and therefore, the Appellant's mother is entitled to \$355,555.20 in compensation. The Department argues that this court previously remanded for a determination of the hours of care within the authorized amount that the mother provided after the

Appellant turned eighteen (18). (R. 3369.) The Department does not dispute that the Appellant's mother may be paid for services she provided, however, the Department argues that the Hearing Officer erred in determining the amount of services that should be used in calculating the reimbursement for the care she provided. Specifically, the Department alleges that the HO erroneously determined that the Appellant was entitled to receive one hundred twelve (112) hours of care per week, and that the HO failed to determine the amount of attendant care the Appellant was authorized to receive and how much of the authorized care the Appellant's mother performed. The court agrees.

DDSN Directive 736-01-DD, titled "Relatives/Family Members Serving As Paid Caregivers of Certain Medicaid Waiver Services," dated November 30, 2017, provides that relative/family members who are a primary caregiver of the waiver participant will not be paid for all of the care they provide, but that the amount to be paid will be based on the waiver participant's needs as determined by their Case Manager in accordance with DDSN policy. The Appellant was authorized ninety-eight (98) hours of care per week, not one hundred twelve (112) hours. Therefore, because DDSN policy only authorizes payment for services based on the participant's needs as determined by their Case Manager, this court concludes that the correct amount of compensation due to the Appellant's mother is \$88,400.40.

The Hearing Officer further found that the Appellant was eligible to receive a speech generating device at the time her doctor ordered it and that the Medicaid program covered the cost of such a device and therefore, ordered the Department to reimburse the Appellant mother's \$8,318.80 to defray the cost of the speech device that she purchased. The Appellant states in her appeal that the Hearing Officer erred in determining the amount due to the Appellant's mother to reimburse her for the speech device she purchased, however, the Appellant fails to provide any argument in support of this assertion. Further, the Appellant fails to expand on this claim and simply requests that the court order the Department to provide the Appellant with a new speech device, which the court declines to do. In sum, substantial evidence in the record mandates that the Department must pay the Appellant a total of \$96,719.20.

6. Did the Hearing Officer err in determining that when a denial of services is appealed, that the denied services must continue until a decision is rendered on the appeal?

The Department argues that the Hearing Officer erroneously concluded that the Department was required to maintain the number of in-home skilled care hours prescribed by the Appellant's treating physician during the pendency of the appeal. The court agrees.

The Hearing Officer concluded that, in light of the complete absence of any medical evidence to the contrary from the Department, the 112 hours per week of nursing care the Appellant's treating physician ordered should have been approved in 2007, and went further to find that the hours should have continued through the final result of this appeal.⁴³ The Hearing Officer did not provide case law or any legal citation to support this finding and the court declines to expand the scope of 42 C.F.R § 431.230 to require that additional services are to be maintained at the rate the participant has requested throughout the pendency of an appeal. Specifically, 42 C.F.R. § 431.230 provides that "[i]f the agency mails the 10-day or 5-day notice as required...and the beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing..." While the Appellant states in her brief that the Appellant "...filed an appeal requesting more hours," the regulation does not provide for the maintaining of services at an additional rate pending the outcome of an appeal from the denial of additional services. (Brief of Appellant/Respondent p. 15.)

ORDER

IT IS HEREBY ORDERED that the decision of the South Carolina Department of Health and Human Services is **AFFIRMED** as **MODIFIED**.

IT IS FURTHER ORDERED that the Department must pay the Appellant's mother \$88,400.40 for services provided and \$8,318.80 to defray the cost of the speech device the Appellant's mother purchased, for a total of \$96,719.20.

AND IT IS SO ORDERED.



S. Phillip Lenski,
Administrative Law Judge

March 21, 2019
Columbia, South Carolina

⁴³ The Hearing Officer also stated that she had no authority to exceed the limits of the waiver program, and that since reaching the age of 21, the Hearing Officer was constrained to find that the Appellant was subject to the waiver limits. Final Order at page 31.

CERTIFICATE OF SERVICE

I, Erika S. Easler, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or by electronic mail to the address provided by the party(ies) and/or their attorney(s).

A handwritten signature in black ink, appearing to read 'E. S. Easler', written over a horizontal line.

Erika S. Easler
Judicial Law Clerk

March 21, 2019
Columbia, South Carolina