Appeal Case # 2013-000762
Atty. Patricia L. Harrison, SC Bar # 11309
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SC ADMIN. LAW COURT

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Richard Stogsdill, Appellant, vs. South Carolina Department of Health and Human Services, Respondent.	**Docket No.: 10-ALJ-08-0774-AP** The Honorable Carolyn C. Matthews March 13, 2013

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SC Court of Appeals

Appearances: Patricia L. Harrison, Esquire, for Appellant
Richard G. Hepfer, Esquire, for Respondent

STATEMENT OF THE CASE

This matter is before me pursuant to the appeal of Richard Stogsdill (Appellant) from the final decision of Respondent, South Carolina Department of Health and Human Services (DHHS). Respondent determined that Appellant failed to state that DHHS by its agent, Department of Disabilities and Special Needs (DDSN), committed an error in fact or law in reducing Appellant's services. Appellant timely appealed that decision to the Administrative Law Court (ALC or Court). The ALC has jurisdiction to hear this matter pursuant to S.C. Code Ann. § 1-23-600 (Supp. 2012).

STANDARD OF REVIEW

This case is before the Court as an appeal from a Final Order of DHHS pursuant to S.C. Code Ann. § 1-23-600(D) of the Administrative Procedures Act (APA). An Administrative Law Judge reviews the case in an appellate capacity under the APA. In South Carolina, the provisions of the APA, specifically, Section 1-23-380(A)(6), govern the circumstances in which an appellate body may reverse or modify an agency decision. That section states:

> 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(A)(6) (2009).

A decision is supported by "substantial evidence" when the record as a whole allows reasonable minds to reach the same conclusion reached by the agency. Bilton v. Best Western Royal Motor Lodge, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984). The well-settled case law in this state has also interpreted the rule to mean that a decision will not be set aside simply because reasonable minds may differ on the judgment. Lark v. Bi-Lo, 276 S.C. 130, 276 S.E.2d 304 (1981). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's finding from being supported by substantial evidence. Waters v. South Carolina Land Resources Conservation Comm'n, 321 S.C. 219, 467 S.E.2d 913 (1996) and Grant v. South Carolina Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995), both citing Palmetto Alliance, Inc. v. South Carolina Public Service Comm'n, 282 S.C. 430, 319 S.E.2d 695 (1984). See also, Miller v. State Roofing Co., 312 S.C. 452, 441 S.E.2d 323 (1994) and Bilton, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984).

In applying the substantial evidence rule, the factual findings of the administrative agency are presumed to be correct. Rodney v. Michelin Tire Co., 320 S.C. 515, 466 S.E.2d 357 (1996), citing Kearse v. State Health and Human Services Finance Comm'n, 318 S.C. 198, 456 S.E.2d 892 (1995). Furthermore, the reviewing court is prohibited from substituting its judgment for that of the agency as to the weight of the evidence on questions of fact. Grant v. South Carolina Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995), citing Gibson v. Florence Country Club, 282 S.C. 384, 318 S.E.2d 365 (1984). Finally, the party challenging an agency action has the burden of proving convincingly that the agency's decision is unsupported by substantial evidence. Waters v. South Carolina Land Resources Conservation Comm'n, 321 S.C. 219, 467 S.E.2d 913 (1996), citing Hamm v. AT&T, 302 S.C. 210, 394 S.E.2d 842 (1994).

Of course, the ALC may always reverse or remand a decision, which is affected by an error of law. Gilliam v. Woodside Mills, et al., 312 S.C 523, 435 S.E.2d 872 (Ct. App. 1993).

However, in reviewing the errors of law asserted by the Appellant, the ALC does need to give deference to the Department's interpretation of its own rules and the relevant federal rules and manual provisions applied. Hampton Nursing Center v. State Health and Human Services Finance Commission, 303 S.C. 143, 399S.E. 2d 434 (Ct. App. 1990) and Ruocco v. S.C. Board of Registration for Professional Engineers and Land Surveyors, 314 S.C. 111, 441 S.E. 829 (Ct. App. 1994).

FACTS/BACKGROUND

Appellant in this matter is a Medicaid-eligible individual, who has been receiving services under the South Carolina Mental Retardation/Related Disabilities (MR/RD) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through the Department of Disabilities and Special Needs (DDSN). Waivers are mechanisms within the Medicaid Program under which, by having certain generic requirements of the Medicaid program "waived," States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. On January 1, 2010, the five-year renewal of the MR/RD Waiver, as approved by the Centers for Medicare and Medicaid Services (CMS), went into effect. The renewed Waiver included a cap or limit on some services and excluded others.

DDSN is responsible for the day-to-day operation of the Waiver. DHHS is the agency that administers the South Carolina Medicaid Program and is responsible for the overall administration of the Waiver. This appeal is directly from the DHHS Decision sustaining the action of DDSN reducing services to Appellant. The reduction was the result of the limitations set forth in the renewed Waiver.

Prior to the Waiver changes, Appellant was receiving a combined 69 hours of Personal Care Aide and Companion Care services per week and about 36 hours of Respite Care per week. Personal Care Aide II (PCAII) services consist of hands-on personal care that a person needs to accomplish their activities of daily living such as bathing, toileting, dressing and eating. Adult Companion Services are similar to PCAII services but include an aspect of community integration. Respite Care can be a range of services, including personal care but is designed to provide services when the normal caregiver is absent or needs relief.

The Waiver capped any combination of PCAII and Adult Companion services at 28 hours per week. The normal cap for Respite Services under the new Waiver is 68 hours per month (or almost 16 hours per week), but exceptions can be granted for up to 240 hours per

month (or about 56 hours per week). Under the new limits, Appellant's services were reduced to 28 hours of PCAII-type services (including Adult Companion services) per week and 68 monthly hours of Respite Care. After the initial cuts, Appellant's Service Coordinator applied for an increase in Respite Care, and Appellant was granted a total of 172 hours of Respite Care per month (or about 40 hours per week).

In accordance with the new Waiver, Appellant's Occupational and Speech Therapies were discontinued. After Reconsideration was denied, Appellant appealed the reductions and the elimination of services to the DHHS Appeals Division. In the Decision of the Department's Hearing Officer, the actions of Respondent were sustained. Appellant subsequently appealed this decision to the Administrative Law Court.

STATEMENT OF ISSUES ON APPEAL

1. Does the substantial evidence in the Record on Appeal support Respondent South Carolina Department of Health and Human Services' decision that changes in the waiver service were lawfully made?
2. Does the agency appeals process have defects that deprive Appellant of due process?
3. Does the substantial evidence in the Record on Appeal support Respondent South Carolina Department of Health and Human Services' decision that the previous Administrative Decision relating to Appellant was carried out insofar as the changes were permitted in the waiver?
4. Does the substantial evidence in the Record on Appeal support Respondent South Carolina Department of Health and Human Services' decision that the integration mandate of the Olmstead case was not violated?

DISCUSSION

1. Changes in Waiver

Section 1915(c) of the Social Security Act [42 USC §1396n(c)] permits states to waive the requirement that persons with mental retardation or a related disability live in an institution in order to receive certain Medicaid services. "[The program] allow[s] states to experiment with methods of care, or to provide care on a targeted basis, without adhering to the strict mandates of the Medicaid system." See Bryson v. Shumway, 308 F. 3d 79 (1st Cir. 2002), cited in Doe v. Kidd, 501 F.3d 348 (4th Cir. 2007). Under S.C. Code Ann. §44-6-5 et seq. DHHS is the single state agency designated to administer the South Carolina's Medicaid Program. §1902(a)(5) [42

USC §396a(a)(5)] and 42 CFR §431.10.

Respondent has the statutory authority to enter into a Waiver agreement with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Program. The major changes include the new limits on Personal Care Aide Services (PCA), Adult Companion Services (ACS), and Respite Care. Speech Language pathology, Occupational and Physical Therapy are among the services eliminated. The elimination of "daily" respite is a reimbursement change, which does not eliminate the service. Therefore, the Departments have properly exercised their authority to amend the Waiver, and CMS, the responsible federal agency has approved the change.

A general notice was sent out to all DDSN clients notifying them of the pending changes and encouraged those affected to work with DDSN Service Coordinators (case managers) to mediate the impact of the new service limits. Service coordinators were trained in the changes. Notices were sent to all beneficiaries who were directly impacted. Service Coordinators contacted the effected clients in order to help rearrange services to get needed coverage within the new Waiver limits.

The general requirements of the services are set forth in 42 CFR §440.230 Sufficiency of amount, duration, and scope, and read as follows:

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

However, §440.230(b) means adequacy of the service as a whole. Therefore, the Hearing Officer could have made a finding that the services to this specific Appellant were insufficient, but would not be able, under §440.230(b) to generalize to the adequacy of the services provided within the Waiver program.

Services have been provided with reasonable promptness, even assuming that the provision of services is included in the reasonable promptness provisions. Sec. 1902(a)(8) [42 USC §1396a(a)(8)] provides as follows:

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

In his Decision, the Hearing Officer specifically found that the services were provided with reasonable promptness. There seems to be a split among the federal circuits with respect to the meaning of the "reasonable promptness" provision, and this and other legal issues were preserved in the Decision for future review. Some courts have held that the reasonable promptness provision only means prompt payment for services received and, by implication, not assuring that the services themselves are rendered. See, Equal Access for El Paso, Inc. v. Hawkins, 562 F.3d 724 (5th Cir.2009); Brown v. Tenn. Dep't of Finance & Admin., 561 F.3d 542, 544-45 (6th Cir.2009); Doe v. Kidd, 501 F.3d 348, 355-56 (4th Cir.2007) and Bruggeman v. Blagojevich, 324 F. 3d 906 (7th Cir. 2003). A few circuits and district courts have gone in the other direction and have treated the Medicaid Act as requiring a state to provide certain actual medical services. Bryson v. Shumway, 308 F.3d 79, 81, 88-89 (1st Cir.2002); Doe v. Chiles, 136 F.3d 709, (11th Cir.1998); Boulet v. Cellucci, 107 F.Supp.2d 61 (D.Mass.2000).

The controversy stems from the definition of "medical assistance" in 42 USC §1396d(a), which now reads as follows:

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

Before the Hearing Officer's Decision in this matter, the underlined and bolded part was added by the Patient Protection and Affordable Care Act (ACA, Pub.L 111-145) effective March 23, 2010. Although the legislative history does indicate that this amendment was intended to correct any misunderstandings of the meaning of the term, it is still for courts to determine the retroactive effect, if any, of the amendment. In any case, any misunderstandings are not relevant here because the Hearing Officer had substantial evidence to find that services themselves had been provided with reasonable promptness. It is the amount of the services that is at issue here.

The Program Coordinator from the District Office received an application from the Service Coordinator to increase the Respite Care to make up for the reduction in PCAII Services. The application was from the Service Coordinator, Ms. Yankowitz. The Service Coordinator had recommended 228 hours of respite services per month. This took into consideration the attending physician's orders, as was required in the previous Administrative Decision. The Service Coordinator's request was within the limits created by the new Waiver. Therefore, I find that the substantial evidence in the Record on Appeal supports the finding that the changes in the waiver were lawfully made.

2. Due Process

Appellant asserts that DDSN's initial notice to Appellant about the reduction in services was defective and in violation of due process because it did not comply with the following regulation:

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

Specifically, Appellant complains that the notice does not adequately describe the action taken by the agency.

The "regulations that support... the action" are set forth in the general description of the home and community based waivers in 42 CFR §440.180 of the Medicaid Regulations which reads in pertinent part:

> 440.180 Home or community-based services.

(a) Description and requirements for services. ``Home or community-based services'' means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

(1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by CMS.

Appellant alleges that his parents were warned that they would be responsible for the cost of services provided during the pendency of the appeal. This is set forth in 42 CFR §435.602(a) which is included in Part 435, Eligibility, of 42 CFR, Subpart G entitled General Financial Requirements and Options:

Sec. 435.602 Financial responsibility of relatives and other individuals.

(a) Basic requirements. Subject to the provisions of paragraphs (b) and (c) of this section, in determining financial responsibility of relatives and other persons for individuals under Medicaid, the agency must apply the following requirements and methodologies:

(1) Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not consider income and resources of any relative as available to an individual.

(2) In relation to individuals under age 21 (as described in section 1905(a)(i) of the Act), the financial responsibility requirements and methodologies that apply include considering the income and resources of parents or spouses whose income and resources would be considered if the individual under age 21 were dependent under the State's approved AFDC plan, whether or not they are actually contributed, except as specified under paragraphs (c) and (d) of this section. These requirements and methodologies must be applied in accordance with the provisions of the
State's approved AFDC plan.

(3) When a couple ceases to live together, the agency must count only the income of the individual spouse in determining his or her eligibility, beginning the first month following the month the couple ceases to live together.

(4) In the case of eligible institutionalized spouses who are aged, blind, and disabled and who have shared the same room in a title XIX Medicaid institution, the agency has the option of considering these couples as eligible couples for purposes of counting income and resources or as eligible individuals, whichever is more advantageous to the couple.

This addresses the calculation of Medicaid eligibility. The Medicaid Fair Hearing regulations allow the agency to recoup the cost of services maintained during the pendency of an appeal:

Sec. 431.230 Maintaining services.

(a) If the agency mails the 10-day or 5-day notice as required under Sec. 431.211 or Sec. 431.214 of this subpart, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless--

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.

Appellant alleges that ex parte communication took place in violation of SC Code Ann. § 1-23-360 which provides:

SECTION 1-23-360. Communication by members or employees of agency assigned to decide contested case.
Unless required for the disposition of ex parte matters authorized by law, members or employees of an agency assigned to render a decision or to make findings of fact and conclusions of law in a contested case shall not communicate, directly or indirectly, in connection with any issue of fact, with any person or party, nor, in connection with any issue of law, with any party or his representative, except upon notice and opportunity for all parties to participate.
An agency member:
(1) May communicate with other members of the agency; and
(2) May have the aid and advice of one or more personal assistants.
Any person who violates the provisions of this section shall be deemed guilty of a misdemeanor and upon conviction shall be fined not more than two hundred fifty dollars or imprisoned for not more than six months.

Ex parte communication was not done by the Hearing Officer, however, there was preliminary communication which took place between DDSN and the Director of the Appeals Division. This communication has not been shown as prejudicial. The person identified by Appellant as having violated this provision was, at the time, the Director of the Division of Appeals and Hearings. He was not the person assigned to make the findings of fact and conclusions of law in this case. Even if he had been the person, it goes against reason that the adjudicator cannot find out what the posture of the case is before issuing a Notice of the Hearing. For the foregoing reasons, I find that adequate due process was afforded to Appellant.

3. Previous Administrative Decision

Respondent asserts that the Decision in the 2009 case of [Appellant] v. SCDHHS, 09-

MISC-017 was a final Order, which the Hearing Officer expected to be carried out. Respondent did not object to the incorporation of the previous case, and the record reflects that the Hearing Officer in this case reviewed it. However, the Hearing Officer declined to apply it dispositively to the Appellant's need for care at this time. Respondent asserts that the previous case ended with the Remand and the Hearing Officer did not retain jurisdiction of the case for further review. The Court agrees.

During the time the previous Order was being implemented, the new Waiver required all services to be reevaluated, taking into consideration the new limits. The evidence substantiates the Hearing Officer's decision to examine the reduction in services to Appellant brought on by the new wavier limits. Moreover, it appears that upon remand to the DDSN, Appellant's case was reevaluated and reauthorized by the new Service Coordinator, taking into account the orders of the Appellant's attending physician. The substantial evidence reflects that the previous administrative decision was carried out while conforming with the changes in the Waiver.

4. The Olmstead Mandate

Olmstead v. L.C. ex rel Zimrig, 527 U.S. 581 (1999) sets forth the requirements for the administering of waiver services. Neither Olmstead nor the DDSN's enabling statutes requires the Department to maintain service at the pre-2010 level. The new waiver went into effect on January 1, 2010. At that time, Appellant was receiving a combined 69 hours of Personal Care Aide and Companion Care services per week and about 36 hours of Respite Care per week.

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

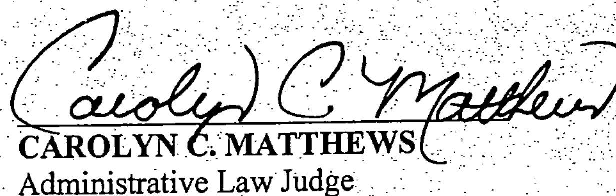
Appellant argues that the Supreme Court in Olmstead said that if the person wants to live in the community and the State's treating professionals think he can and the State can reasonably accommodate such a placement, then the person should be supported in the community. The proposed cuts in services to Appellant, could lead to his having to be institutionalized, and, therefore, the cuts should be prohibited.

Appellant is living in the community, and it is speculative as to whether the reduction in services will cause him to be institutionalized. If it is assumed to be true that he would be

institutionalized, the State's responsibility under Olmstead (to support a person in the community) is not boundless. Olmstead, at 603. If the accommodation would fundamentally alter the State's program, the State does not have to make the accommodation.

ORDER

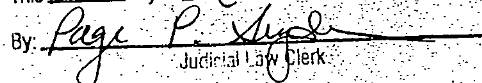
THEREFORE, IT IS HEREBY ORDERED that the decision of the South Carolina Department of Health and Human Services is **AFFIRMED**.



CAROLYN C. MATTHEWS
Administrative Law Judge

March 13, 2013
Columbia, South Carolina

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the Interagency Mail Service addressed to the party(ies) or their attorney(s).



This 13 day of March 2013
By: Judicial Law Clerk