No. _____

In The
Supreme Court of the United States

RICHARD STOGSDILL, ET AL.,
Petitioners,

v.

THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES COMMISSION,
Respondent.

On Petition for Writ of Certiorari
to the United States Court of Appeals
for the Fourth Circuit

APPENDIX

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UNPUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 22-1069

RICHARD STOGSDILL; NANCY STOGSDILL, Parent of Richard Stogsdill, on behalf of themselves and other similarly situated persons,

Plaintiffs - Appellants,

and

ROBERT LEVIN; MARY SELF, Parent of Robert Levin, on behalf of themselves and other similarly situated persons,

Plaintiffs,

v.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendant - Appellee,

and

KATHLEEN SEBELIUS; CYNTHIA MANN; JOHN DOES 1-20; CMS; ANTHONY KECK,

Defendants.

Appeal from the United States District Court for the District of South Carolina, at Columbia.
Joseph F. Anderson, Jr., Senior District Judge. (3:12−cv−00007−JFA)

Submitted: February 22, 2023 Decided: June 6, 2023

Before AGEE, HARRIS, and QUATTLEBAUM, Circuit Judges.

Affirmed by unpublished per curiam opinion.

Patricia Logan Harrison, Cleveland, South Carolina, for Appellants. Damon C. Wlodarczyk, RILEY, POPE & LANEY, LLC, Columbia, South Carolina, for Appellee.

Unpublished opinions are not binding precedent in this circuit.

PER CURIAM:

In 2012, Richard Stogsdill, Robert Levin and their parent caregivers sued the South Carolina Department of Health and Human Services and related individual defendants (collectively, the "SCDHHS") in the District of South Carolina seeking declaratory and injunctive relief. On multiple grounds, they challenged South Carolina's Medicaid waiver program, established under 42 U.S.C. § 1396n(c), which provides home and communitybased services to certain individuals with severe disabilities and allows individuals to avoid institutionalization. Stogsdill and Levin, two severely disabled individuals, receive such medical equipment and services. Following a bench trial and extensive motions practice, the district court entered judgment granting the plaintiffs' request for declaratory relief as to a determination about the provision of a single piece of medical equipment, a water walker, and denied all other requested relief. Stogsdill, Levin and their parent caregivers appealed. Considering the entire record and applicable law, we affirm.

In 2010, the SCDHHS implemented amendments to the waiver program that capped certain community-based services and eliminated others. As a result, Stogsdill and Levin experienced a reduction in the services they received. Stogsdill moved for the reconsideration of the reduction of services provided to him and, after the denial of that motion, appealed administratively and to the South Carolina Court of Appeals. Levin did not request such reconsideration.

Stogsdill, Levin and their parent caregivers also brought this action in federal court with a lengthy list of claims against the SCDHHS for alleged violations of the Americans with Disabilities Act ("ADA"), Section 504 of the Rehabilitation Act, 42 U.S.C. § 1983, the Medicaid Act, the Administrative and Procedures Act of the State of South Carolina and the Supremacy and Due Process Clauses of the United States Constitution. In the following years, the parties have engaged in significant motions practice and the district court has conducted several bench trials. The court issued multiple orders that have narrowed the issues, claims, and parties in the case. And we have considered two prior appeals of the district court's decisions.

The last time the case was before us, in March 2019, we affirmed the careful and thoughtful judgments of the district court in nearly all respects but remanded Stogsdill's claims against the state defendants which the district court declined to consider based on abstention principles in light of parallel proceedings taking place in state court. *Stogsdill v. Azar*, 765 F. App'x 873, 877 (4th Cir. 2019).

After we remanded on that limited issue, the district court considered the remaining claims. It dismissed most of those claims based on a combination of preclusion, the outcome of state court litigation and a consent order. But as to the remaining claims, it conducted another bench trial. Following the trial, the district court denied all requested relief except for Stogsdill's request for declaratory relief as to the reasonable promptness provision of the Medicaid Act set forth at 42 U.S.C. § 1396a(a)(8) with respect to Stogsdill's specific request for a water walker, which it granted.

The district court also determined that the SCDHHS provided notice and an opportunity for a fair hearing with respect to the requested medical equipment in accordance with 42 U.S.C. § 1396a(a)(3) and the regulations. In sum, other than as to the provision of the water walker, the district court concluded that Stogsdill, Levin and their parent caregivers failed to carry their burden of proof showing entitlement to any relief as to any remaining claims. The district court also denied their motion to alter or amend the judgment. Stogsdill, Levin and their parent caregivers appealed that order as well as any other appealable orders below. JA8559; JA8570.

On appeal, Stogsdill, Levin and their parent caregivers argue that the SCDHHS violated the integration mandate of the ADA and the Rehabilitation Act by failing to make reasonable modifications in the State's programs, and that the district court erred in its rulings concerning these provisions. They also argue that the SCDHHS violated their constitutional and statutory rights under 42 U.S.C. § 1983, including rights guaranteed

under the Constitution of the United States and the Medicaid Act, particularly the reasonable promptness mandates at 42 U.S.C. § 1396a(a)(3) and 42 U.S.C. § 1396a(a)(8) and the requirements of 42 U.S.C. § 1396n(c)(2) to assure the financial accountability.

But in their opening brief, Stogsdill, Levin and their parent caregivers advance only conclusory arguments and fail to dispute the district court's reasoning or to articulate any meritorious basis for reversal of the court's judgment. This constitutes waiver under our precedent. *See Grayson O. Co. v. Agadir Int'l LLC*, 856 F.3d 307, 316 (4th Cir. 2017) ("A party waives an argument by failing to present it in its opening brief or by failing to develop its argument—even if its brief takes a passing shot at the issue.") (cleaned up); *see also Timpson ex rel. Timpson v. Anderson Cnty. Disabilities & Special Needs Bd.*, 31 F.4th 238, 256–57 (4th Cir. 2022) (finding appellants' argument waived where they "presented no basis for reversing the judgment below."). And to the extent not waived, upon review of the record, we affirm the district court and find no reversible error.

We dispense with oral argument because the facts and legal contentions are adequately presented in the materials before the court and argument would not aid the decisional process.

AFFIRMED

FILED: 12/21/21

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA

C/A No. 3:12-cv-0007-JFA

Richard Stogsdill, Nancy Stogsdill, Mother of Richard Stogsdill, Robert Levin, and Mary Self, Mother of Robert Levin,

Plaintiffs,

vs.

The South Carolina Department of Health and Human Services,

Defendant.

ORDER

This matter is currently before the Court on Plaintiffs Richard Stogsdill and Nancy Stogsdill's (collectively "Plaintiffs") motion to alter or amend this Court's previous Findings of Facts and Conclusions of Law (ECF No. 474) and subsequent judgment (ECF No. 475) issued after the most recent bench trial in this action. (ECF No. 477). Having been fully briefed, this matter is now ripe for consideration.

I. FACTUAL AND PROCEDURAL HISTORY

The relevant factual and procedural history is outlined in the Court's previous order at issue (the "Order") and is incorporated herein by reference. (ECF No. 474). By way of brief recitation, the Court

recently concluded the fourth bench trial in this decade old matter wherein all of Plaintiffs' remaining claims were presented. Through a series of prior orders, several of Plaintiffs' claims were adjudicated or otherwise dismissed well before the instant trial. However, a portion of Plaintiffs' claims, predominantly Plaintiffs' claims centered on the provision of medical equipment with "reasonable promptness," remained as a justiciable controversy.

These claims proceeded to a bench trial before the undersigned in which the parties presented evidence on July 8, 9, 12 and 19, 2021, and the Court heard additional arguments on August 16, 2021. The Court issued an order on October 5, 2021 including the findings of fact and conclusions of law relevant to these claims as required by Rule 52 of the Federal Rules of Civil Procedure. (ECF No. 474). Plaintiffs apparently take issue with several of these findings of facts and conclusions of law and have asserted the instant motion in an effort to amend the Order and consequently alter the resulting judgment. Having been fully briefed, this matter is now ripe for review.

II. LEGAL STANDARD

Motions under Rule 59 are not to be made lightly: "[R]econsideration of a previous order is an extraordinary remedy, to be used sparingly in the interests of finality and conservation of judicial resources." 12 James Wm. Moore et al., Moore's Federal Practice ¶ 59.30[4] (3d ed.); *Doe v. Spartanburg Cty. Sch. Dist. Three*, 314 F.R.D. 174, 176 (D.S.C. 2016) (quoting *Pac. Ins. Co. v. Am. Nat. Fire Ins.* Co., 148 F.3d 396, 403 (4th Cir. 1998)). Courts "have recognized three grounds for amending

an earlier judgment: (1) to accommodate an intervening change in controlling law; (2) to account for new evidence not available at trial; or (3) to correct a clear error of law or prevent manifest injustice." *Hutchinson v. Staton*, 994 F.2d 1076, 1081 (4th Cir. 1993). To be clearly erroneous, the earlier decision cannot be "just maybe or probably wrong; it must ... strike [the Court] as wrong with the force of a five-week old, unrefrigerated dead fish." *TFWS, Inc. v. Franchot*, 572 F.3d 186, 194 (4th Cir. 2009) (quoting *Bellsouth Telesensor v. Info. Sys. & Networks Corp.*, Nos. 92-2355, 92-2437, 1995 WL 520978 at *5 n.6 (4th Cir. Sept. 5, 1995))

Rule 59(e) motions "may not be used to make arguments that could have been made before the judgment was entered." *Hill v. Braxton*, 277 F.3d 701, 708 (4th Cir. 2002). Nor are they opportunities to relitigate issues already ruled upon. *Pac. Ins. Co.*, at 403 (4th Cir. 1998) (quoting Wright et al., *supra*, § 2810.1, at 127–28). Motions to reconsider are not "opportunities to rehash issues already ruled upon because a litigant is displeased with the result." *R.E. Goodson Constr. Co., Inc. v. Int'l Paper Co.*, No. 4:02-4184-RBH, 2006 WL 1677136, at *1 (D.S.C. June 14, 2006) (citing *Tran v. Tran*, 166 F. Supp. 2d 793, 798 (S.D.N.Y. 2001)).

"A motion to alter or amend a judgment must be filed no later than 28 days after the entry of the judgment." Fed. R. Civ. P. 59(e).

Plaintiff also seeks relief from the judgment pursuant to Rule 60 "on the grounds of mistake, newly discovered evidence and fraud, and such other grounds that may justify relief." (ECF No. 477, p. 1). Relevant here, motions based on fraud, mistake, or newly discovered evidence must made no more than

a year after the entry of the relevant judgment or order. Fed. R. Civ. P. 60(c).

III. DISCUSSION

Initially, the Court would note that Plaintiffs' attempts to "incorporate by reference all objections previously made at trial and in hearings, motions, responses, replies and other filings, including, but not limited to ECF numbers 103, 110, 134, 136, 138, 187, 192, 214, 221, 240, 296, 313, 321, 322, 324, 366, 385, 387, 390, 401, 403, 409, 412, 417, 435, 440, 444, 451, 457, 466, 468 and 473, together with all with attachments" for "purposes of issue preservation" is improper as motions to alter or amend are not opportunities to rehash issues already ruled upon because a litigant is displeased with the result. Moreover, motions to reconsider are unnecessary for issue preservation. *Henry A. Knott Co., Div. of Knott Indus. v. Chesapeake & Potomac Tel. Co. of W. Virginia*, 772 F.2d 78, 81 n.3 (4th Cir. 1985).

Additionally, several of Plaintiffs' arguments are subject to summary dismissal as they attempt to relitigate decisions made over a year ago which have themselves been reaffirmed in prior orders adjudicating Plaintiffs' previous motions to alter or amend. (ECF Nos. 381 & 394, 395)[1]. Specifically, Plaintiffs attempt to again challenge this Court's orders (1) dismissing the director of DHHS[2] (ECF

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[1] ECF No. 381 was filed on March 23, 2020; ECF No. 394 was filed on July 6, 2020; and ECF No. 395 was filed on July 6, 2020.

[2] Anthony Keck previously served as Director of DHHS and has since been succeeded by Robert Kerr. Plaintiffs therefore request Kerr be substituted for Keck in his official capacity.

Nos. 131 & 381); (2) dismissing all claims other than those related to equipment, supplies, and assistive technology (ECF No. 395); (3) dismissing claims of violation of Plaintiffs' due process rights (ECF No. 381); (4) dismissing claims of violation of the South Carolina Administrative Procedures Act (ECF Nos. 131 & 381); and (5) dismissing claims of violation of the Americans with Disabilities Act (ECF No. 381).

In addition to constituting an attempted third bite at the apple, Plaintiffs' motion on these issues comes more than twenty-eight days after the various orders adjudicating them were filed and, therefore, the motion is untimely as to these arguments. Fed. R. Civ. P. 59(b). To the extent Plaintiffs are seeking relief under Fed. R. Civ. P. 60(b), Plaintiffs' motion was filed more than one (1) year after the various orders were entered and, therefore, is untimely. Fed. R. Civ. P. 60(c)(1). Thus, Plaintiffs' motion is denied as to these arguments.

In an apparent attempt to avoid the untimely nature of their arguments, Plaintiffs cite to Rule 54 within their Reply brief which allows the Court to revise a previous ruling "any time before the entry of a judgment adjudicating all the claims." Fed. R. Civ. P. 54(b). However, Plaintiffs' attempt to utilize Rule 54 is inapplicable here given that a final judgment has been entered in this action. (ECF No. 475).
However, Plaintiffs' motion is timely to the extent it seeks to alter or amend determinations made in Order after the most recent bench trial in this action.

Initially, Plaintiffs seek to have this Court amend its determinations that Defendant acted with

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This request is moot given the Court's denial of the motion to reconsider the director's previous dismissal from the action.

reasonable promptness when supplying Richard with a water walker[3], a stander, a ceiling lift, a gait trainer, ankle-foot orthosis ("AFOs"), door opener, and a wheelchair.

Plaintiffs' arguments regarding the Court's determinations on reasonable promptness each appear to be nothing more than a mere rehashing of those positions previously advanced at trial and within Plaintiffs' proposed findings of facts (ECF No. 466). As noted by Defendant, Plaintiffs have failed to show a clear error of law, new evidence, or a change in law sufficient to warrant any alteration or amendment in the Order. Although Plaintiffs take issue with the time calculations issued in the Order (i.e., the dates the clock started and stopped when determining reasonable promptness), their arguments amount to mere disagreements with the Court's rationale. As stated above, this is not a proper basis for altering or amending the Court's order.

Plaintiffs also request that the Court "alter or amend is ruling as it relates to 42 U.S.C. 1396a(a)(17)." However, they offer no argument as to why the Court's original ruling was clearly erroneous. Therefore, Plaintiffs' motion is denied on this ground as well.

Plaintiffs also appear to assert arguments not seen before including reference to new regulations and wavier application documents. Specifically, Plaintiffs argue that this Court failed to appropriately apply federal regulations at 42 C.F.R.

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[3] Although the Court agreed with Plaintiffs that the water walker was not provided with reasonable promptness, Plaintiffs disagree with the methodology and reasoning used to reach this determination.

§ 441.301(b)(1)(i) and § 441.303(c). (ECF No. 477, p. 32-33). A review of Plaintiffs' proposed findings of fact and conclusions of law show a total absence of any reference to 42 C.F.R. § 441.303 and a single passing reference to 42 C.F.R. 441.301. (ECF No. 466, p. 32)("In April 2003, DDSN approved Doe's a 'plan of care,' pursuant to 42 C.F.R. § 441.301(b), which included residential habilitation services."). Because motions to alter or amend are not opportunities to advance arguments a party could have, yet failed to make earlier, such reliance on previously unutilized regulations is improper here.

The same is true for Plaintiffs' arguments related to alleged violations of 42 U.S.C. § 1396(n). This statute appears only once within Plaintiffs' proposed findings of fact and conclusions of law. However, this single reference is contained within a block quote and not included in any substantiative argument put forth by Plaintiffs. (ECF No. 466, p. 33). Accordingly, Plaintiffs' attempts to articulate new legal arguments is improper grounds for altering or amending the Court's prior Order.[4] Plaintiffs were given unfettered opportunity, at their request (ECF No. 456), to submit their position via proposed findings of facts and conclusions of law. The failure to properly advance arguments now elucidated for the first time is not a proper ground for altering or amending a prior order. *Hill v. Braxton*, 277 F.3d 701, 708 (4th Cir. 2002)("Rule

[4] To clarify, the full text of 42 U.S.C. § 1396(n) and 42 C.F.R. 441.301 were included in Plaintiffs' exhibits attached to their proposed findings of fact and conclusions of law. (ECF No. 466-1). However, Plaintiffs failed to specifically articulate how these provisions applied or how Defendant violated these provisions in regard to Richard.

59(e) motions may not be used to make arguments that could have been made before the judgment was entered.").

Plaintiffs and Defendant also discuss new developments, occurring after the close of the bench trial, related to Richard's continued need for incontinence supplies such as catheters, leg bags, and connective tubing. As discussed in the Order, it appears that Richard has again experienced confusion as to the proper source of funding for his needed incontinence supplies. However, it also appears that any confusion or dispute as to the source of funding for these supplies has been settled by way of consent order dated October 8, 2021 issued as a result of a recent administrative appeal. (ECF No. 476, p. 39-48). Accordingly, no further action is needed on this matter as Plaintiffs have received assurances that "DDSN shall continue to pay for all incontinence supplies as previously provided through the ID/RD wavier by DDSN unless and until DHHS assumes responsibility for payment of the cost of these supplies, without interruption of these services." (ECF No. 476, p. 43). This consent order "fully resolves [Plaintiffs] appeal of the termination of services." (ECF No. 476, p. 48). Any violations of this consent order should be enforceable via the administrative review process. Thus, any "new evidence"[5] provided by Plaintiffs does not warrant any alteration or amendment to the Court's Order.

A dditionally, although Plaintiffs attempt to introduce new evidence in both their initial motion and in the Reply brief, it appears that this evidence only shows ongoing proceedings including another

[5] The Court would note that this evidence is not new evidence heretofore undiscovered, but rather evidence of new conduct.

administrative appeal over the continued funding for Richard's incontinence supplies. None of the evidence presented indicates that Richard has gone without his incontinence supplies, only that the source of funding is somehow still in dispute. This new evidence, all apparently formulated after the close of trial in this decade old matter, is not proper grounds for an alteration or amendment of the previous order.

The Court cannot allow this action to linger on in a state of continuous litigation to serve as tertiary source of administrative oversight whenever Plaintiffs face a procedural challenge.[6] This Court understands Plaintiffs' frustrations and has attempted to adjudicate all claims grounded in the burdensome procedure Plaintiffs must endure when requesting equipment. However, the issues in this lawsuit must be adjudicated with some finality.

Plaintiffs' claims of "ongoing" violations does not somehow transform this Court into an ever-present avenue of direct relief to be called upon throughout Richard's lifetime. Any new issues arising since the entry of final judgment or in the future may serve as grounds for separate administrative claims or possible lawsuits. However, the issues in this case have been presented and adjudicated. The Court sees no reason to alter or amend the final judgment previously entered.

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[6] The Court would note that the issues surrounding Richard's incontinence supplies was raised for the first time in the most recent bench trial in this action. The Court cannot reasonably be expected to reopen the record, expand the scope of Plaintiffs' allegations, and conduct an entirely new trial in response to each conceivable qualm Plaintiffs may experience with this Defendant into perpetuity.

Additionally, to clarify, Plaintiffs' current motion is one to alter or amend a previous final judgment or for relief from that judgment. (ECF No. 477, p. 1)("Pursuant to Rules 59 and 60 of the Federal Rules of Civil Procedure Plaintiffs move for an order altering or amending the Court's 'Findings of Fact and Conclusions of Law' and Judgment."). Accordingly, Plaintiffs' later request for relief pursuant to Rule 54; a new trial pursuant to Rule 59(a)(2); or to reopen the judgment pursuant to Rule 59(a)(2) are procedurally improper as these arguments appear for the first time in Plaintiffs' Reply brief [7]and the time to file such motions has expired. Fed. R. Civ. P. 59(b).

IV. CONCLUSION

For all of the reasons stated above, Plaintiffs' motion to alter or amend the Order or for relief from judgment (ECF No. 477) is respectfully denied.

IT IS SO ORDERED.

December 21, 2021

/S/ Joseph F. Anderson, Jr.
Columbia, South Carolina
United States District Judge

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[7] "The ordinary rule in federal courts is that an argument raised for the first time in a reply brief or memorandum will not be considered." *Clawson v. FedEx Ground Package Sys., Inc.*, 451 F. Supp. 2d 731, 734 (D. Md. 2006)(citing *United States v. Williams,* 445 F.3d 724, 736 n. 6 (4th Cir.2006)).

FILED: 10/5/21

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA

C/A No. 3:12-cv-0007-JFA

Richard Stogsdill, and Nancy Stogsdill, Mother of Richard Stogsdill,

Plaintiffs,

vs.

South Carolina Department of Health and Human Services,

Defendant.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter is currently before the Court on the recently concluded bench trial of those claims remaining in this action. The parties presented evidence on July 8, 9, 12 and 19, 2021. On Plaintiffs' request, the Court also accepted proposed findings of fact and conclusions of law from each party. (ECF Nos. 466 & 467). Upon receiving and reviewing the proposed findings and conclusions, the Court heard additional argument on August 16, 2021. After receiving the testimony, carefully considering all of the evidence, weighing the creditability of the witnesses, reviewing the exhibits and briefs, and studying the applicable law, this Court makes the following Findings of Fact and Conclusions of Law pursuant to Fed. R. Civ. P. 52. The Court notes that

to the extent any of the following Findings of Fact constitute Conclusions of Law, they are adopted as such, and to the extent any Conclusions of Law constitute Findings of Fact, they are so adopted.

I. PROCEDURAL HISTORY

Prior to delving into the testimony and exhibits presented during this bench trial, the Court feels that a brief recitation of the complex procedural history is necessary to fully understand the issues remaining in this action.

This case originated out of the reduction in benefits provided to two Medicaid-eligible individuals, Richard Stogsdill ("Richard") and Robert Levin, and the impact upon their mothers, Nancy Stogsdill ("Nancy") and Mary Self, respectively. Plaintiffs initiated this suit by bringing claims against various state and federal agencies and their respective officials. Initially, this Court adjudicated Levin's claims but abstained from adjudicating Richard's claims pursuant to the *Rooker-Feldman* doctrine and other prudential abstention grounds. Plaintiffs' first appeal to the Fourth Circuit was remanded for lack of appellate jurisdiction. (ECF No. 266). Essentially, the Fourth Circuit determined that this Court had failed to rule on Plaintiffs' discrete retaliation claims[8] and remanded for further proceedings. On remand, this Court held another

[8] The Fourth Circuit did note that this Court did not adjudicate these retaliation claims "through no fault of its own, given the complexity of the plaintiffs' complaint and the minimal factual development of the retaliation claims – and thus had not issued a final judgment." *Stogsdill v. S.C. Dep't of Health & Human Servs.*, 674 F. App'x 291, 293–94 (4th Cir. 2017).

bench trial in which it determined that Plaintiffs had not proven a claim for retaliation. Plaintiffs again appealed.

The Fourth Circuit concluded the second appeal by affirming the judgments of this Court in nearly all respects. (ECF No. 357). However, the Fourth Circuit also held this Court erred in dismissing Stogsdill's claims against the state defendants for lack of jurisdiction under the *Rooker-Feldman* doctrine and in otherwise abstaining from reviewing the claims. *Stogsdill v. Azar*, 765 F. App'x 873, 881 (4th Cir. 2019). When the Court abstained from deciding the issues presented by the Stogsdill plaintiffs, Richard's claims were then pending before the state courts. By the time this case reached the Fourth Circuit a second time, the intervening period had allowed the state courts to conclude their work. Therefore, abstention was clearly no longer appropriate.

Consequently, Richard and Nancy's claims within the Second Amended Complaint ("SAC") (ECF No. 72) were revived and remanded for further proceedings. Upon remand, the only remaining defendants were Anthony Keck[9] and the South Carolina Department of Health and Human Services ("SCDHHS" or "DHHS"). Although the Fourth Circuit held that abstention was not applicable in this case, it did state that "ordinary preclusion principles still apply." (ECF No. 357, p. 14). Thus,

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[9] Defendant Anthony Keck was then dismissed via this Court's order dated March 23, 2020 because claims against both Keck and SCDHHS are duplicative as any judgment rendered against Keck in his official capacity as director of SCDHHS would be tantamount to a judgment against SCDHHS itself. (ECF No. 381).

the parties were asked to provide additional briefing on the application of preclusion doctrines to these remaining claims.

Prior to ruling on this issue, this Court held a status conference wherein both parties represented that Richard had initiated further proceedings before the Administrative Law Court and was appealing preliminary decisions. The parties also represented that they were attempting resolution of Plaintiffs' requests and hoped they could reach a settlement. Consequently, the undersigned stayed all proceedings to allow the parties to work towards an amicable resolution. (ECF No. 379). Sometime thereafter, the parties submitted a status report in which they advised that Plaintiffs' administrative appeal had been resolved by consent order in which Richard "received all relief which may be granted." (ECF No. 380-1).

Accordingly, this Court then ruled on the preclusion issues and asked the parties to provide additional briefing as to the effect of that consent order on the claims remaining here (i.e., whether the consent order rendered the remaining claims moot). (ECF No. 381). After additional briefing, this Court then issued an order in which it held that, of those claims remaining, Plaintiffs' causes of action contained in Claims 4 and 6 of the SAC had not been completely mooted by the consent order. (ECF No. 395). Although Plaintiffs' claims regarding a desire for increased nursing hours were moot, the claims as related to the ongoing need for medical equipment were not moot. Thus, the remaining claims at issue from Plaintiffs' SAC include Violations of Section

504 of the Rehabilitation Act[10] (Claim 4) and Violations of 42 U.S.C. § 1983[11] (Claim 6)—but only as related to the need for medical equipment.

Consequently, the Court then allowed a brief period of discovery to ascertain Richard's current need, if any, for medical equipment. Thereafter, the Court proceeded to the instant bench trial in this case. Shortly before the bench trial began, the Court held a pretrial conference wherein the parties advised that all of the medical equipment previously requested by Richard had been provided to him with the exception of a water walker. Moreover, the request for the water walker had been approved and payment authorized. The parties were waiting on payment to be sent to the water walker manufacturer who would then ship the device directly to Richard. Although it appeared that Richard had no further outstanding requests for medical devices or equipment, Plaintiffs maintained that a controversy still existed because their issue was, and always had been, centered around the

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[10] Plaintiffs' § 504 claim is based upon allegations that SCDHHS has failed to make funds available, failed to make reasonable modifications to the waiver programs, failed to provide services in the least restrictive setting and failed to utilize criteria and methods of administration, all of which created an unnecessary risk of institutionalization and segregation prohibited by § 504.

[11] Plaintiffs' § 1983 claim seeks to remedy violations of certain provisions of the Medicaid Act including: claims related to the fair hearing system (42 U.S.C. § 1396a(a)(3)); reasonable promptness (42 U.S.C. § 1396a(a)(8)); amount, duration and scope (42 U.S.C. § 1396a(a)(10)); reasonable standards (42 U.S.C. § 1396a(a)(17)); and feasible alternatives (42 U.S.C. § 1396n(c)(2)).

process used to request and obtain medical equipment.[12]

Thus, the Court proceeded to the fourth bench trial in this case. Based on its intimate knowledge of this case and its prior experience with Plaintiffs' counsel in presenting evidence, the Court found it prudent to limit the presentation of evidence to 9 hours per side. (ECF No. 434). The Court granted Plaintiffs' counsel considerable leeway in presenting evidence she felt was relevant to the remaining claims subject only to this time limitation. The Court also granted Plaintiffs' midtrial request for additional time by offering another hour to each side. Plaintiffs' attorney was moreover granted additional time to cross examine Defendant's one rebuttal witness despite the expiration of her 10-hour limit. Defendant utilized only a fraction of the time allotted.

At trial, the Court received testimony from several witnesses including case managers Audry Grant,[13] Jessica Kibler,[14] and Mckenzie Johnson.[15] As Plaintiffs' counsel has done in the prior trials in this action, several witnesses presented provided little, if any, information relevant to Richard's

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[12] Although previously dismissed as moot, Plaintiffs also contend that this process for requesting equipment is the same process used to determine the need for care hours and is problematic for many of the same reasons.

[13] Grant is a case manager supervisor at Richland/Lexington Special Needs Board ("Rich/Lex").

[14] Kibler is Richard's current case manager at Rich/Lex.

[15] Johnson was Richard's prior case manager from 2015–2019 at an organization known as Bright Start.

claims. Moreover, the undersigned had to order several of Richard's case managers to appear *sua sponte*. These case managers had intimate firsthand knowledge of the processes Richard undertook for each piece of equipment and the Court found their testimony vital in determining the relevant facts in this action.

The Court would also note that Plaintiffs' counsel offered into evidence over 150 exhibits consisting of nearly 7,500 pages prior to this trial. A vast majority of the exhibits have no relevance to the remaining claims and were not used or referenced during trial.[16] Of these 7,500 pages, Plaintiff utilized less than 200 (less than 3%) during trial. Instead, Plaintiffs' counsel proceeded to introduce new exhibits (approximately 100 additional pages over and above the 7,500 previously identified) during trial despite the case being nine years old and discovery closing months prior to trial. Plaintiffs' counsel additionally submitted new witness affidavits and attachments which contained "newly discovered evidence"[17] weeks after Plaintiffs rested their case.[18] (ECF Nos. 468 & 469). Moreover, several exhibits were misnumbered, omitted, or duplicated which caused numerous delays and confusion during trial. In order to provide Plaintiffs

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[16] Several of the exhibits were full copies of depositions and transcripts of prior hearings in this case with no indication as to what portions, if any, were relevant.

[17] Despite being "newly discovered", these exhibits ranged in age from 9 months to several years old.

[18] To be sure, Defendant submitted additional affidavits and attachments as well, but did so only in response to Plaintiffs' untimely submissions.

the opportunity to fully present their remaining claims with a complete record, the Court allowed in almost every piece of evidence or testimony offered by Plaintiffs' counsel.

Despite repeated requests for counsel to identify information and supporting evidence, the Court found it extremely difficult to extract specific facts, such as precise dates of equipment requests, necessary for adjudicating this action. However, this Court has attempted to untangle the convoluted sum of evidence presented to reach a final resolution of this case. From the testimony and voluminous exhibits presented, the Court finds the following facts and conclusions of law.

II. FINDINGS OF FACT

Richard, now in his mid-thirties, has had cerebral palsy since birth which has resulted in spastic quadriplegia. He requires the use of several pieces of medical equipment including a wheelchair, stander, gait trainer, and door opener as well as medical supplies such as catheters and urine collection bags. Richard also requires around the clock care and receives varying levels of service from providers throughout the day. Richard's mother, Nancy, serves as Richard's primary caregiver and point of contact. Richard is eligible for both Medicare and Medicaid benefits. Because he is at risk of institutionalization, Richard is also entitled to additional benefits via the intellectual disability/related disability ("ID/RD")[19] wavier. The ID/RD waiver allows Richard to access additional

[19] Richard's cerebral palsy is considered a "related disability" thus entitling him to certain benefits under the ID/RD waiver.

services in the community without the need to be institutionalized.

The crux of Plaintiffs' claims centers on the byzantine process used to request medical equipment and the inevitable delay caused by trudging through the various pitfalls along the way. Plaintiffs have continued to complain about process issues regarding DHHS' failure to administer Medicaid waiver programs in compliance with federal and state law from the outset of this litigation. Thus, an explanation of the process in general is essential in adjudicating these claims.

The Request Process

Through the testimony of Nancy, the case managers mentioned above, and various state agency employees, the Court was able to piece together the process envisioned in requesting medical equipment by ID/RD wavier participants. Although each request for medical equipment may require some deviation from this specific procedure, the general process is outlined below.

Part of Richard's benefits include access to case management services. Case management organizations contract with and are funded by the Department of Disabilities and Special Needs ("DDSN"). Richard employs the use of a case manager to navigate the labyrinthine system used to request medical equipment, supplies, and services from Medicare and Medicaid. Richard has the freedom to choose the provider of his case management services. Richard previously utilized a case management company called Bright Start from

2014 through June 2019. He then transferred[20] to an independent case management company for a brief period before transferring to Oconee County Disability and Special Needs Board ("Oconee") on July 18, 2019. Richard then transferred from Oconee to Richland/Lexington Special Needs Board ("Rich/Lex") on August 3, 2020 because Oconee stopped providing case management services. Rich/Lex remains Richard's current case management provider.

The first step of case management services begins with Richard's annual assessment. Case managers are required to complete a written assessment every 365 days. Richard's assessment typically occurs sometime in August-September each year. This allows case managers an opportunity to meet with Richard and his care givers, such as his mother Nancy, to discuss his current condition and needs. From this assessment, the case manager completes the annual plan of care (also referred to as a "care plan" or "support plan"). Certain requests from care givers for medical equipment are included within the plan of care as "needs".[21] This plan of care is then submitted to the Waiver Administration

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[20] Plaintiffs aver that they left Bright Start because the case manager was not providing adequate services. Nancy also took issue with a new Bright Start directive that required additional face-to-face visits which were burdensome for Richard.

[21] Although the care plan identifies certain "needs," this term is not synonymous with a determination of "medical necessity." A determination of medical necessity can only be made by a medical professional and is prerequisite to Medicaid funding. This medical professional need not be a recipient's primary physician but can also include other professionals such as a physical therapist.

Division ("WAD") of DDSN for approval. The plan of care was described as a "living document" that can be amended or updated by the case manager at any time via a change request. Thus, should the need for a new piece of equipment, or repair to an existing piece, arise after the annual assessment, a case manager may submit a change request to include the new need. DDSN, through the WAD, also reviews and approves each change request. No party disputes that Richard's needs for medical equipment occasionally change over time. For instance, his wheelchair or lift may need periodic maintenance, repair, or replacement. Additionally, he may outgrow certain pieces of equipment or his medical condition may change which will generate the need for a new piece of equipment.

After the care plan is approved, the case manager then works with the benefit recipient such as Richard (the "recipient") or his care giver, such as Nancy, to obtain necessary equipment. Once a piece of equipment is identified as a need within a care plan, the case manager will then work to obtain the necessary documentation and prepare a funding request packet to be sent to Medicare. Medicare is considered Richard's primary insurer and is the payor of first resort. The case manager often obtains a quote from an equipment provider and a prescription or related letter of necessity ("LoN") from a medical professional to submit with the request.[22] A recipient is entitled to freedom of choice and thus has the ability to choose his own provider

[22] Recipients may sign releases that allow case managers to communicate directly with a recipient's physicians. However, the physician is under no obligation to comply with a case manager's requests.

for services or equipment.[23] 42 C.F.R. § 431.51. Oftentimes a case manager is called upon to provide recommendations for providers, but the recipient is entitled to make his or her own choices. The case manager often has prior experience with certain providers and has knowledge of those which are already enrolled with Medicare/Medicaid. Other times, a recipient or caregiver will choose a provider they have worked with in the past or otherwise prefer.[24] Evidence showed that case managers, recipients, and their care givers work as a team to obtain the necessary documentation. For instance, Nancy and a case manager would often discuss and decide amongst themselves who would be responsible for obtaining a specific LoN or quote from a provider.

Once a provider is identified and proper documentation gathered, the case manager coordinates with a provider to submit the request package to Medicare. The provider submits the request as it is a request for payment. However, the case manager continues to monitor the provider's request and deliver additional information or support if needed. If approved by Medicare, payment is authorized, and the provider may then supply the piece of equipment. Once the equipment is supplied, payment to the provider is then issued.

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[23] This freedom of choice also extends to case management services.

[24] Evidence indicated Nancy has a great deal of past experience with certain providers, such as National Seating and Mobility ("NSM"), and would often request they be used as Richard's equipment provider without the need for referrals from a case manager.

If Medicare denies a request, the provider may then request payment from Medicaid (also referred to as "state plan Medicaid" or simply the "state plan"). Participants in South Carolina submit their requests to Medicaid through a third-party administrator known as Kepro. Kepro conducts reviews of requests for medical equipment including an assessment of medical necessity and may then approve or deny the request. If approved, payment is authorized, and the provider may then supply the piece of equipment. If denied, the equipment provider may then request a reconsideration. Several witnesses in the trial before this Court stated that only providers are allowed to request a reconsideration from Kepro. Recipients are not able to participate in the Kepro process. No witness presented at trial knew the standards Kepro used in its assessment process.

After Kepro denies a reconsideration request, the case manager works with the provider to then submit the request through the ID/RD wavier. The ID/RD wavier is a subdivision of Medicaid and is considered the payor of last resort. If the request for equipment is denied by Kepro because it is not deemed medically necessary, the recipient may then submit a request on the grounds that the requested equipment may provide some remedial benefit or otherwise enhance independence. Evidence of this remedial benefit often requires additional documentation from a medical professional. If approved, payment is authorized, and the provider may then supply the piece of equipment. Once the equipment is supplied, payment to the provider is then issued. Case managers continue to monitor progress after payment is authorized to ensure the

device or service is actually delivered and satisfactory.

If the request for equipment is denied by the ID/RD wavier, the recipient may request a reconsideration from DDSN. If the reconsideration is denied, the recipient may then file an administrative appeal through the Division of Appeals and Fair Hearings at DHHS.[25] If the fair hearing appeal is not resolved in the recipient's favor, he may then appeal the fair hearing decision to an administrative law court. Administrative law court decisions may then be appealed directly to the South Carolina Court of Appeals. The exact time required to provide an approval or denial from each of these three steps (Medicare, Medicaid, ID/RD wavier) is unknown and varies from situation to situation. However, testimony indicated that 10 to 14 days to receive a response from each of the three levels was not unusual.

Throughout this process, case managers note the status of such requests in a computer program known as Therap. Personnel at DHHS and DDSN also have access to this Therap program. Nancy does not have access to Therap. Although she testified that she had previously requested access to Therap, Nancy could not remember when or to whom such a request was made. Testimony showed that at least one other recipient has been given access to Therap.

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[25] The parties appear to agree that the jurisdiction of the fair hearing division extends only to suspensions, terminations, denials, or failure to provide equipment or services. Thus, the fair hearing division does not have jurisdiction to issue constitutional determinations or otherwise determine if alleged actions violate the reasonable promptness mandate, the amount duration and scope mandate, the ADA, or the Rehabilitation Act.

However, no one testified as to the level of access to Therap or any other information specific to this other recipient's individual situation. No witness was able to identify what measures, training, or costs would have to be put in place to provide recipients and caregivers access to Therap. At all times, the case manager works as the recipient's liaison between the caregivers, various governmental agencies, Medicare, Medicaid, and providers to supply information and support needed to effectuate these requests. Accordingly, the Court acknowledges that it may be beneficial to provide recipients or caregivers access to Therap, but there is no indication that caregivers such as Nancy could not obtain the same information or receive status updates by simply calling or emailing their case managers.

In receiving testimony from various case managers at different agencies, it became apparent that these case managers are extremely involved in the process and vital in ensuring requests are processed correctly and timely.[26] Additionally, the case manager closely monitors the progress of any request made and keeps the recipient or caregiver informed of that progress. Richard's current case manager meets with him quarterly and at least two of these visits are face-to-face within his home. Case managers also make monthly calls to recipients to note their current status and additional needs. Other than qualms with a certain manager at Bright Start, Nancy testified that case managers were

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[26] If the Medicare/Medicaid regulatory scheme can be described as the dreadful underworld in which Plaintiffs purportedly find themselves when making requests, then these case managers serve as the ferryman on the river Styx.

readily available to answer her questions and provide assistance. Nancy and her attorney Patricia Harrison[27] regularly communicated with case managers via phone calls and emails.

This precise process is not specifically explained within any written manual or procedures readily available to recipients or their care givers. However, case managers were readily available to help recipients and care givers with their requests. Additionally, the case managers stated that they could reach out to personnel at DDSN or DHHS for assistance in this process at any time. Certain portions of the process, such as coding used to request common pieces of equipment or procedures to request a fair hearing, are available in writing in various locations such as the DDSN Wavier Manual or the DHHS website.

Moreover, this process is subject to variation depending on each specific request. For instance, case managers may be aware that a particular piece of equipment may not be covered under Medicare and will thus proceed directly to Medicaid via Kepro. Certain requests, such as repairs or maintenance to existing equipment, would not require documentation from a medical professional. In other instances, a provider may need additional information prior to providing a quote and submitting a request. For instance, the provider may need to request measurements from the recipient or

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[27] Harrison has served as the Stogsdill's attorney throughout this federal litigation as well as in their various state administrative proceedings. Moreover, Harrison was heavily involved in day-to-day dealings and communications with case managers, DHHS, DDSN, and other entities. Several of Harrison's own emails were used as exhibits in trial.

schedule a home visit to assess the device or service needed. Moreover, medical professionals may require in person fittings or evaluations prior to preparing the necessary LoN. No witness at trial knew the standards utilized by Kepro in determining whether a device was medically necessary, or the criteria used in evaluating requests.

No witness at trial was familiar with a specific "reasonable promptness" mandate or knew of any 90-day requirement for the provision of equipment or services.

With this general process in mind, the Court now turns to Richard's specific requests for equipment.

Water Walker

Richard previously utilized a water walker[28] which he has since outgrown. Richard's most current care plan dated October 5, 2020 identified a new water walker as a need. There was no evidence of any procurement activity related to the water walker from any party until January 22, 2020 when Richard's current case manager, Kibler, communicated with Nancy and her attorney to learn that Nancy had reached out to the provider and requested a quote. At that point, the case manager had yet to receive any quote or LoN.

Kibler later received a quote of approximately $250 from the water walker manufacturer on March 2, 2021. This water walker is a specialized device available only through a specific manufacturer

[28] A water walker is a device used to stabilize Richard during aquatic therapy.

known as Theraquatics.[29] Upon receiving the quote, the case manager conferred with Nancy and Harrison about the need for a doctor's LoN. Nancy then volunteered to request a LoN and/or a prescription from Richard's physician.[30] Shortly thereafter, Richard needed immediate medical attention and the COVID-19 pandemic escalated in the United States. These two factors caused a 3-week delay in Nancy's ability to request a LoN from Richard's physician. The case manager spoke with Nancy on March 24, 2021 and Nancy confirmed she was still waiting to hear back from Richard's physician on the necessary documentation. Richard's physician ultimately faxed a copy of the LoN to the case manager on March 25, 2021. The case management office received the fax, but it was misplaced in a separate set of documents. In a monthly follow-up call on April 30, 2021, the case manager again inquired into the LoN and learned that it had been previously faxed. The physician then faxed another copy of the LoN to the case manager on the same day. Upon receipt of the LoN, that case manager had the necessary documentation to submit the request packet.

The request was then submitted through the ID/RD wavier and approved on May 3, 2021, after

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[29] Theraquatics appears to be an Australian company with its American operations based in Montgomery, Alabama.

[30] Nancy and the case manager often discussed needs for additional documentation and would delegate the responsibility to obtain this documentation amongst themselves on a case-by-case basis. Nancy testified that she would volunteer to gather such information in an effort to expedite the process. However, she believed the case manager was the person responsible for gathering such documentation.

the case manager provided additional information about Richard's prior water walker to the WAD. The case manager informed Nancy and Harrison of the approval on the following day. For uncertain reasons, payment for this piece of equipment was required prior to the provision of the water walker.[31] However, before payment for the water walker could be issued, Theraquatics had to create an account in DDSN's electronic documentation system. This particular provider was not enrolled in Medicaid and thus could not bill directly for the equipment. Further, the provider, an out-of-state company, declined to enroll directly with Medicaid. Therefore, Richard's case manager had to request payment be made by his financial manager, Kershaw County Disabilities and Special Needs Board ("Kershaw").[32] Kershaw initially refused to issue payment. Richard's case manager then followed up with a DDSN agent Carol Mitchell to identify the issue with Kershaw's refusal to pay. After further conversations, Mitchell confirmed that DDSN would reimburse Kershaw for the water walker payment

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[31] As stated above, payment was normally authorized prior to the provision of equipment but not issued until after the equipment had been received.

[32] This process of acquiring payment through a special needs board is referred to as "board billing." If a provider is enrolled with Medicare/Medicaid, they may utilize "direct billing" to receive payment directly from Medicare. Although a provider must be given the ability to direct bill Medicaid for specialized medical equipment, supplies, and assistive technology, the providers are not required to enroll and direct bill.

and Kershaw agreed that payment could be made.[33] Because the water walker provider was an out-of-state company not enrolled with Medicaid, additional steps had to be taken to verify their business license before payment could be authorized. Case management notes evidence the case manager's repeated efforts over the course of several weeks in attempting to confirm Kershaw would issue payment and gathering the necessary information to get Theraquatics approved for payment. After these delays, Kershaw issued payment for the water walker on July 7, 2021. Richard received the water walker on July 29, 2021.

Stander

Nancy expressed a desire for a stander to Richard's case manager at some point in early 2018. Records indicate that Dr. Jill Monger created a LoN for a stander on May 2, 2018. Additionally, quotes for a stander were generated no later than May 16, 2018. Emails between the provider, case manager, and WAD Director Ben Orner dated from June 27, 2018–September 5, 2018 show that the chosen provider was attempting to submit a request for payment to Kepro with no success.[34] After consulting with Richard's Bright Start case manager, the provider again submitted its request to

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[33] After making payment, Kershaw would then seek reimbursement from DDSN who would get payment from DHHS.

[34] The provider had apparently failed to show Medicare exhaustion in addition to using the wrong coding to request this particular piece of equipment.

Kepro utilizing different coding on September 6, 2018.

Medicaid, through Kepro, denied this request on September 12, 2018. This denial was evidenced in a letter to Richard dated September 21, 2018. This denial letter noted that a request for a stander was made by the provider National Seating and Mobility. However, the letter also stated the request was denied because: "Per physician review, 'long-term functional debility and wheelchair dependance, not clear that a stander will provide additional measurable benefit for this 31 year old patient.'" The letter also stated that "[w]e will be happy to send you a copy of the criteria we used for the review by calling 1(855)326-5219." The following information was also included:

> If you do not agree with this decision, you can send a letter asking for reconsideration. You must send a copy of this denial letter and any documents to show why you need the service within 60 days of the date this letter. You may submit your reconsideration request via fax, KEPRO Atrezzo Portal 1 or mail; however, the preferred method is fax (1-855-300-0082). If submitting via mail, reconsideration requests must be sent to:
>
> KEPRO
> 2810 N. Parham Rd.
> Suite 305
> Henrico, VA 23294
>
> If the service is denied again you will have the option to contact the SCDHHS Division

of Appeals and Hearings and request a State Fair Hearing to appeal the decision. The denial notice that you receive after the reconsideration will explain the process to request a State Fair Hearing.

A beneficiary may request an expedited appeal. SCDHHS will grant or deny these requests as quickly as possible. If we grant your request to expedite, your appeal will be resolved as quickly as possible instead of the standard 90-day timeframe. If we deny the request to expedite, the appeal will follow the standard 90-day timeframe.

SCDHHS may grant expedited review if we determine the standard appeal timeframe could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. SCDHHS may consider, among other facts:

- the medical urgency of the beneficiary's situation
- whether a needed procedure has already been scheduled
- whether a beneficiary is unable to schedule a needed procedure due to lack of coverage
- whether other insurance will cover most of the costs of the requested treatment.

You may request an expedited appeal at the same time you file your appeal request or after you file an appeal. Please state you are requesting an expedited appeal and explain why.

> To avoid delays in the process, please submit any supporting documentation with the request for expedited review or immediately thereafter. While supporting documentation is not required, SCDHHS will make its determination based on the information made available at the time we consider the request.
>
> If you have any questions please call us at (855) 326-5219.
>
> Sincerely,
> KEPRO South Carolina QIO Medical Management

This denial letter was sent directly to Richard and a similar letter was sent to the provider. Nancy testified that she never requested a reconsideration or attempted to contact Kepro as provided in the letter partly because she had been instructed that only providers could request reconsideration from Kepro. Emails dated September 24, 2018 indicate that the provider informed Richard's case manager that the stander request had been denied. Other emails on the same day show that Orner instructed the case manager that she or Richard's attorney could work with the provider to appeal the denial if they felt the denial was not correct. Orner further advised the case manager that the ID/RD wavier was not likely to fund the stander for the same reasons unless a remedial benefit could be shown.

Richard's October 9, 2018 care plan again listed the stander as a need and noted that Nancy and Harrison were attempting to get documentation from

Richard's physician to show the stander would provide a remedial benefit in support of a request for wavier funding. Case manager Johnson stated that Harrison volunteered to obtain additional documentation from Jill Monger to indicate the stander would provide a remedial benefit so they could request a reconsideration.

Case notes indicate that the case manager sent Harrison another copy of the denial letter on February 21, 2019, per Harrison's request. The case manager met with Nancy and Harrison on March 12, 2019 to again discuss the stander. A March 27, 2019 email from the case manager to Nancy indicated that the case manager was still waiting on additional information from Richard's physician to request the stander through the wavier.

Emails dated April 9, 2019 and April 17, 2019 noted that Harrison and Nancy had yet to provide the case manager with the documentation from a medical professional needed to show a remedial benefit prior to requesting wavier funding. Nancy then transferred Richard's case management services away from Bright Start in June 2019. Thus, a reconsideration or subsequent request was never initiated by this case manager.

Attorney Harrison then requested a reconsideration from DDSN in a letter written on November 11, 2019. This request for reconsideration was directed primarily at the reduction in Richard's nursing hours. The letter did mention medical equipment but did not specifically identify the stander. DDSN director Mary Poole denied this request for additional nursing hours via letter dated November 22, 2019. Poole's letter did not address a request for a stander. Harrison then initiated an

appeal of the denial of Richard's request for additional nursing hours and the denial of the stander on December 11, 2019 to the fair hearing division.[35] This appeal resulted in a January 28, 2020 consent order in which DHHS agreed to provide the stander for Richard in addition to providing the additional nursing hours requested. The stander was actually delivered to Richard on July 2, 2020. The provider apparently did not have this specific stander readily available to deliver and the delay from January 28, 2020 to July 2, 2020 was due to the provider's need to procure the stander requested.

Door Opener

Richard's residence had a door opener which was originally installed more than 10 years ago. Although Plaintiffs' counsel argued at trial that the need for a new door opener was originally identified in 2012, she has since noted this argument was in error. The need for repair to his existing door opener was first noted on March 21, 2019 when Harrison contacted the Bright Start case manager.[36]

Emails dated March 27, 2019 indicate that the case manager informed Nancy that her preferred provider, National Seating and Mobility ("NSM"), did not provide door openers and she would have to choose a separate provider. Later, on April 1, 2019, Nancy indicated that she had spoken with NSM and

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[35] The initial appeal notice did not specifically reference a stander but a later email from Harrison to DHHS dated December 17, 2019 confirmed that they were appealing the denial of the stander as well as the denial of additional nursing hours.

[36] Richard's October 9, 2018 care plan does not identify the door opener as a need.

learned that they do provide door openers, but only out of their Charlotte office. The Bright Start case manager testified that she then made arrangements for a provider representative to stop at Richard's house and evaluate his needs on his next visit to Columbia. However, Nancy transferred Richard from Bright Start to Oconee before the provider could appear for the inspection. Plaintiffs presented no evidence as to any efforts made while at Oconee to request a door opener.

In August 2020, Richard transferred case management services from Oconee to Rich/Lex. The Rich/Lex case manager listed a door opener as a need on Richard's October 5, 2020 care plan.

Case manager notes indicate that Nancy requested a quote from the provider on November 17, 2020. Notes indicated that the case manager spoke with a NSM representative on December 22, 2020 to discuss his plan to inspect the current door opener the following Monday. The representative needed to inspect the current door opener to assess to the possibility of repair or the need for a full replacement. The case manager then received a quote for a full replacement of the door opener on January 7, 2021 and composed a change request to the care plan. This change request was immediately returned by DDSN and Kibler had to request additional information from Nancy including the age of the current door opener. Kibler submitted another change request with this additional information and the door opener was added to the plan of care the same day. Kibler informed Nancy and Harrison that the door opener had been approved and a request was sent to NSM to replace the door opener.

The door opener was installed no later than January 29, 2021. The door opener was funded through the ID/RD wavier. The case manager was able to get this request approved with only a quote and no need for a prescription or LoN.

Ankle Foot Orthoses

Richard has utilized ankle foot orthoses ("AFOs") for several years and Nancy discussed the need for new ones with Richard's Bright Start case manager in March 2019. That case manager provided Nancy with a list of AFO providers on March 27, 2019. However, Nancy transferred Richard from Bright Start before a request was ever made. Additionally, Plaintiffs presented no evidence of any requests for AFOs made while at Oconee. Richard then transferred to Rich/Lex in August 2020.

After transferring to Rich/Lex, AFOs were identified as a need in Richard's October 5, 2020 care plan. On December 4, 2020, notes show that the case manager received a prescription for AFO braces along with provider information. The case manager then informed Nancy as to her next steps in requesting the AFOs. On January 22, 2021, the case manager noted that Nancy had reached out to an AFO provider to request a quote but had yet to receive one. On March 24, 2021, the case manager called Nancy to check the status of the AFOs and learned that Richard had been experiencing some health problems that delayed his ability to go and get fitted for the AFOs. On this same day, the case manager also confirmed that the AFOs would be fully funded through Medicare or Medicaid. Nancy acquired these braces from the provider later that

same day. There is no indication of when a quote from the provider was ever received.

Gait Trainer

The need for a new gait trainer (also referred to throughout trial via its brand name "Rifton Pacer" or erroneously as "Piston Racer") was identified in Richard's October 8, 2019 and October 5, 2020 care plans.[37] On November 17, 2020, Nancy contacted case manager Kibler to discuss the need for equipment including a gait trainer. Richard previously had a gait trainer obtained in 2014, but could no longer acquire replacement parts for it. Therefore, a new one would be needed. Nancy had requested quotes for this product and Kibler instructed her that medical justification would be needed as well. On December 4, 2020, notes show that Kibler received a prescription for the gait trainer. On December 14, 2020, Kibler received a quote from NSM and then corresponded with a funding specialist at NSM regarding Richard's gait trainer. Notes indicate that Kibler "received and reviewed the quote, medical letter of necessity, and prescription for the item since Richard's family has expressed how much this item is needed since his current one is not working properly." Kibler submitted a request for the gait trainer on the same day and notified Nancy and Harrison of the request. Kibler proactively submitted the request directly to the ID/RD wavier and had the provider

[37] Although Richard's 2012 care plan identified a gait trainer as a need, his October 2018 care plan did not identify a gait trainer as a need. Plaintiffs presented no evidence of efforts to obtain a gait trainer from 2012 to 2020.

simultaneously submit a request through Kepro to expedite the process. Kibler received notification from the provider on January 13, 2021 that Kepro had approved the gait trainer and it had been ordered from the manufacturer. Kibler informed Nancy and Harrison of this approval on the same day. The gait trainer was delivered to Richard on February 16, 2021. Ceiling Lift

Richard utilizes a ceiling lift in transferring to his wheelchair. In October 2018, notes indicate the lift needed a new motor. This need was marked "completed" on March 22, 2019 along with the statement that "mom reported the lift is in fair condition and working for now."

Richard's October 5, 2020 care plan identified additional problems with the lift as a need. November 17, 2020 notes indicate Nancy called the case manager to inform her that Nancy had requested a quote for repairs. On January 8, 2021, Nancy avers that she was forced to pay $855.82 out-of-pocket to the provider for an inspection and battery needed for the celling lift.[38] Nancy asserts that she had to make an advanced payment before the provider would schedule an inspection and she had no time to wait for Medicaid approval. Although Nancy claims this cost should be covered by Medicaid and she should be reimbursed for the $855.82 that she paid out-of-pocket, she produced no evidence showing that she ever notified the case manager or another person at DDSN of this payment. She did not request reimbursement until

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[38] Evidence of Nancy's out-of-pocket payment was not introduced until weeks after Plaintiffs rested their case. Despite this untimely production, the Court allowed in the evidence to form a complete record of Plaintiffs' claims.

August 10, 2021 (after trial) when her attorney emailed a request to in-house counsel for DHHS.

Kibler's later notes stated that Nancy obtained a bill for needed repairs to Richard's lift on January 13, 2021. This bill showed a $0 balance. Apparently, Nancy never informed the case manager that she herself had paid this bill because on January 14, 2021, Kibler, believing the $0 balance to be erroneous, then contacted the provider to obtain a copy of the invoice that did not show a $0 balance. Kibler then composed a change request to request funding from the ID/RD wavier. The change request was approved the next day on January 15, 2021. Kibler informed Harrison and Nancy of this progress.

Kibler then received a second quote for repairs from the provider on January 22, 2021 and Kibler had to request additional documentation from the provider to clarify the additional costs. This second quote of $821.52 covered replacement of certain safety devices on the lift. Kibler then submitted a change request on the same day. She also communicated with the provider to learn that this invoice was different than one previously produced because the first invoice was for the battery to be replaced and the inspection and the second invoice was for the repairs to the safety equipment in the lift system. She added this information to the change request.

The change request was approved by the WAD on January 26, 2021. Kibler informed Nancy and Harrison of this approval on the same day. She also contacted the provider to inform them of the approval so they could schedule the repairs. On February 17, 2021, the case manager followed up

with the provider to confirm the authorization and have the provider confirm they would complete the repairs. On March 1, 2021 Kibler again contacted the ceiling lift provider to inform the provider that the authorization for the repairs was previously sent. The provider then notified Kibler that the necessary parts "have now shipped." The lift was repaired on March 26, 2021.

Plaintiffs further allege that they learned for the first time on August 10, 2021 that the bill for repairs to the safety features was sent to Kershaw and remains unpaid. However, Plaintiffs do not dispute that the actual repairs have been made and payment has been authorized. DHHS provided evidence that Kershaw mailed a check for $821.52 to the provider on July 29, 2021.

Wheelchair

The need for a new motorized wheelchair was listed in Richard's October 9, 2018 care plan. An email from Nancy to Richard's Bright Start case manager dated January 22, 2019, indicates that Nancy had a prescription and was in the process of scheduling an appointment with Dr. Jill Monger to have Richard fitted for his new wheelchair. Case management notes show that by March 22, 2019, Richard had been fitted for a wheelchair and was "still waiting on insurance approval." Plaintiffs presented no evidence as to what "insurance" this note refers to or the efforts made to get the funding approved. However, it is presumed this insurance refers to Medicare, Richard's primary insurer, given that notes dated May 2, 2019, state that Medicare approved funding the wheelchair. In the same notes,

funding for a seat height adjustment accessory for the wheelchair was noted to be denied by Medicare but the case manager would request funding through the ID/RD wavier based on remedial benefit. Notes dated May 6, 2019 show that funding for the height adjustment accessory had been approved by the wavier. The case manager informed Nancy and Harrison of the approvals on the same day. Richard's wheelchair was delivered on December 11, 2019. Plaintiffs presented no evidence as to the cause of delay between the May 2019 approval and December 11, 2019 delivery.

Catheter Supplies

For the first time in this litigation, Plaintiffs presented evidence at this trial of issues related to the funding of tubing used to connect Richard's catheter to his urine collection bag. Richard had recently received a denial of funding for this tubing from Medicaid. However, DHHS has been providing funding on 30-day intervals for this tubing through the ID/RD wavier on a temporary basis to ensure Richard has the necessary supplies. Witnesses at trial appeared to agree that the tubing provider had submitted a request for payment to Medicaid using the wrong coding. Thus, case managers were working with the provider to correct the code and resolve the funding issue.[39] There is no indication that Richard does not currently have the necessary supplies or that he is in immediate risk of going without them. Jennifer Jaques, a WAD supervisor,

[39] Testimony suggested that funding for these supplies should be provided by Medicaid without a problem if the correct coding was used.

testified that a future request for temporary funding through the wavier would be approved if the funding issue with Medicaid could not be fixed before his supplies ran out. Moreover, Plaintiffs' proposed findings of fact has no reference to catheters whatsoever. Thus, there appears to be no issues which this Court can currently rectify and any ruling on this matter would be premature.

Throughout all of these processes, Nancy was in constant contact with Richard's various case managers. Moreover, Plaintiffs' attorney, Harrison, was present or included in a vast majority of the contacts each case manager had with Richard and Nancy. Case managers Johnson and Kibler both stated it was a rare occasion in which they would communicate with Nancy without having Harrison present or copied on her communications. Harrison was present during face-to-face meetings, copied on email communications, and even communicated directly with case managers. Case manager records show that several conversations with Harrison were had in which she would request changes[40] to Richard's proposed plan of care prior to submission. Case managers would also work to keep Harrison updated along with Nancy.

Other Witness Testimony

Apart from the case managers' and Nancy's testimony discussed above, Plaintiffs presented several other witnesses in their case-in-chief. A summary of their respective testimony is below.

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[40] Most of these changes were to modify the verbiage used in the care plan.

Deborah McPherson

Plaintiffs presented Deborah McPherson as one of their initial witnesses. McPherson is a former employee and commissioner for DDSN. She retired in 2009 and worked on the commission for DDSN from 2009–2014. McPherson had absolutely no knowledge of Richard's needs or particularized requests for equipment. It appears she was presented as a witness solely to voice her generalized concerns with DHHS including its failure to promulgate regulations and its handling of Medicare and Medicaid funding requests.

Margaret Alewine

Plaintiffs also called Margaret Alewine in their case-in-chief. Alewine is a program manager for community options within DHHS. This division has authority over the ID/RD wavier division. Alewine offered no specific insights as to Richard's dealings with DHHS and offered only her general knowledge of DHHS.

Tara Derrick

Similarly, Tara Derrick was presented as a witness. Derrick works at DHHS and her job responsibilities include helping determine which items of durable medical equipment are covered by Medicaid. She offered no testimony specific to Richard and added little, if anything, to the case. She did testify that she understood Kepro to have 15 days to review and respond to a request for authorization. She also testified that Richard's

catheter tubing is covered under state plan Medicaid.

Jennifer Jaques

Plaintiffs additionally presented testimony from Jennifer Jaques. Jaques is a supervisor at the WAD and worked as a case manager for several years prior. Jaques prepared an assessment of Richard on July 28, 2015 after being given some of Richard's records by a DHHS attorney and Dr. Platt. Jaques did not perform any in-person interviews or speak with Nancy, Richard, or his case manager prior to drafting the assessment. This short assessment essentially concluded that additional in-person interviews and inspection of Richard's home would be necessary to provide a complete assessment of Richard's current condition and needs—including his need for medical equipment. This assessment was apparently performed in response to the remand of Richard's parallel action in the South Carolina state court.[41]

Within the assessment, Jaques notes that an in-person consultation was needed, but Richard's attorney, Harrison, would not permit such an inspection. Later emails revealed that Harrison and Nancy requested an in-person inspection by Dr. Platt, but conditioned it on the presence of Richard's attorney, Harrison, or his godfather, who was also an attorney. Moreover, Harrison demanded that Dr. Platt disclose his contractual relationships and financial dealings with DHHS or DDSN prior to the evaluation. It does not appear that Dr. Platt ever

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[41] *Stogsdill v. S.C. Dep't of Health & Human Servs.*, 410 S.C. 273, 763 S.E.2d 638 (Ct. App. 2014).

performed an in-person inspection. However, there is no indication that Richard did not thereafter continue to receive his annual assessments and follow up visits from his respective case managers. It is unclear what relevance, if any, Jaques' testimony, or prior assessment has on Plaintiffs' current claims in this court.

Mary Poole

Plaintiffs additionally elicited testimony from Mary Poole who served as director of DDSN from September 2018 through February 2021. Poole had recently been terminated from this position and filed a lawsuit against DDSN alleging various claims. Her lawsuit has no relevance to Plaintiffs' claims. Moreover, Poole had no information specific to Richard's claims. Other than authoring a letter denying Richard's reconsideration request in December 2020, Plaintiffs presented no evidence of Poole's direct involvement with Richard's various requests.

Robert Kerr

Robert Kerr previously served as the Director of DHHS and resigned in 2007. After that, he contracted with DDSN to provide consulting services. At the time of trial, he had again been serving as director of DHHS for two months. Although the Court expressed doubts as to the relevancy of any testimony provided by Kerr, Plaintiffs' counsel was allowed to question him on matters she felt necessary subject only to the Court's greater time limit on the presentation of evidence.

As suspected, Kerr had no knowledge specific to Richard or his claims. His testimony did not aid in making any determinations contained in this order.

Beverly Buscemi

Beverly Buscemi previously worked for DDSN from 2009–2017. She testified generally about the request process but had no information specific to Richard's requests.

Band Payments

Throughout this litigation, Plaintiffs have taken issue with the funding system utilized by DDSN. Specifically, Plaintiffs allege that the use of a so-called "band funding system" caused delays in funding for services and equipment or was otherwise illegal. Testimony at trial showed that the band payment system utilized by local boards in relation to wavier participants such as Richard was disbanded as of January 1, 2021.

Plaintiffs' counsel avers that this is incorrect and local boards, such as Kershaw, continue to utilize the band funding system for wavier participants. However, Plaintiffs conflate band funding and board billing. It is undisputed that local boards may still issue payments when providers do not direct bill Medicaid. However, the funding used to make this "board-billed" payment no longer comes from a certain pre-issued funding band. Instead, the local board issues payment and then directly bills the DDSN wavier program to recover that cost. The DDSN wavier program then bills DHHS for that cost. Thus, to the extent that any of Plaintiffs' claims

rest on the use of a band funding system, those claims are now moot.

III. CONCLUSIONS OF LAW

Those claims remaining before the Court include a claim pursuant to § 504 of the Rehabilitation Act based upon allegations that SCDHHS has failed to make funds available, failed to make reasonable modifications to the waiver programs, failed to provide services in the least restrictive setting, and failed to utilize criteria and methods of administration—all of which created an unnecessary risk of institutionalization and segregation prohibited by § 504.

Additionally, Plaintiffs' § 1983 claim seeks to remedy violations of certain provisions of the Medicaid Act including: claims related to the fair hearing system (42 U.S.C. § 1396a(a)(3)), reasonable promptness (42 U.S.C. § 1396a(a)(8)), amount, duration and scope (42 U.S.C. § 1396a(a)(10)), reasonable standards (42 U.S.C. § 1396a(a)(17)), and feasible alternatives (42 U.S.C. § 1396n(c)(2)).

Plaintiffs are not requesting any monetary damages or compensation for past injuries or violations. Instead, they seek only declaratory and prospective injunctive relief.

Medicaid

Medicaid is an optional, federal-state program through which the federal government provides financial assistance to states for the medical care of needy individuals. *Wilder v. Va. Hosp. Ass'n,* 496 U.S. 498, 502 (1990). Once a state elects to

participate in the program, it must comply with all federal Medicaid laws and regulations. *Id.* "Spanning hundreds of regulations across fourteen parts and scores of subparts in the Code of Federal Regulations, Medicaid is—to put it mildly—a complicated program to administer." *K.C. ex rel. Afr. H. v. Shipman*, 716 F.3d 107, 119 (4th Cir. 2013).

To aid in the complicated administration, regulations call for the designation of a single state agency to administer or supervise administration of a state's Medicaid program. 42 U.S.C. § 1396a(a)(5). SCDHHS is the single state agency responsible for administering and supervising Medicaid programs in South Carolina. DDSN has specific authority over the state's treatment and training programs for people with intellectual disabilities and related disabilities. The Wavier Administration Division is a subdivision of DDSN created to review annual plans of care and other requests of wavier participants. Case managers work for local disabilities and special needs boards or other independent providers and are contracted by DDSN for the provision of services to Medicaid recipients. *Kobe v. Haley*, 666 F. App'x 281, 284 (4th Cir. 2016).

Despite the subdivision of responsibility between these various agencies, DHHS remains the agency accountable for administrative oversight and adherence with federal law. DHHS "may not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters." 42 C.F.R. § 431.10(e); *Kobe v. Haley*, 666 F. App'x 281, 299 (4th Cir. 2016). In other words, DHHS may not contract away its obligations or accountability. *K.C. ex rel. Afr. H. v. Shipman*, 716 F.3d 107, 112

(4th Cir. 2013)("[T]he vesting of responsibility over a state's Medicaid program in a single agency safeguards against the possibility that a state might seek to evade federal Medicaid requirements by passing the buck to other agencies.").

Reasonable Promptness: 42 U.S.C. § 1396a(a)(8)

All of the statutory and regulatory provisions identified by Plaintiffs above present overlapping claims which essentially take aim at the complicated process Richard has been forced to endure upon each request for a change in service hours or for a specific piece of medical equipment.

Central to these claims is Plaintiffs' contention that DHHS must provide services with "reasonable promptness." 42 U.S.C. § 1396a(a)(8). They further contend that the Fourth Circuit Court of Appeals has defined reasonable promptness as a period not to exceed 90 days. At the very least, Plaintiffs contend that a detailed status report should be sent explaining any delay over 90 days. Moreover, Plaintiffs contend that the 90-day clock should start the day Richard's annual assessment, or any subsequent change order, is approved by the WAD and end when Richard physically receives the equipment.

Although the Fourth Circuit has referenced certain Medicaid regulations that have a 90-day deadline, it is unclear which provisions are controlling here. In first holding that a plaintiff may enforce the reasonable promptness provision found in § 1396a(a)(8) pursuant to § 1983, the Fourth Circuit held that:

> the provision is not so "vague and amorphous" that the judiciary cannot competently enforce it: the provision is clear that the standard for informing applicants of their eligibility for Medicaid services is "reasonable promptness" and the relevant federal and state regulations and manuals define reasonable promptness as forty-five days or ninety days, depending on the applicant. *See, e.g.,* 42 C.F.R. § 435.911[42]; South Carolina Medicaid Manual, cited at J.A. 242; United States Department of Health & Human Services Center for Medicaid and State Operations, Olmstead Update No: 4, at J.A. 290. Third, the provision uses mandatory rather than precatory terms: it states that plans "must" provide for assistance that "shall" be delivered with reasonable promptness. *See* § 1396a(a)(8).
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> *Doe v. Kidd*, 501 F.3d 348, 356 (4th Cir. 2007) ("*Doe I*").

However, in a subsequent Opinion within that same case, the Fourth Circuit also stated:

> Defendants argue that *Doe I* misapplied 42 C.F.R. § 435.911, which appears to establish a timeline whereby a state agency must make a determination as to eligibility, but not a timeline for when an agency must actually furnish services. (Appellees' Br. at

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[42] Although this Opinion references 42 C.F.R. § 435.911, the 90 and 45-day provisions are contained in 42 C.F.R. § 435.912.

> 39–40.) They would have us instead rely upon § 435.930, which states only that Medicaid services are to be made available "without any delay caused by the agency's administrative procedures." *See, e.g., Doe 1–13 By and Through Doe, Sr. 1–13 v. Chiles,* 136 F.3d 709, 721–22 (11th Cir.1998) (upholding a district court's conclusion that "reasonable promptness" means a period not to exceed ninety days). Because we find that Defendants have never provided Doe with the appropriate services, we will not address these more subtle issues of timeliness.
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> *Doe v. Kidd*, 419 F. App'x 411, 416 n.2 (4th Cir. 2011)("*Doe II*").

Thus, the Fourth Circuit has not specifically defined "reasonable promptness" as applied to the provision of equipment or services to an individual previously qualified to receive Medicare or Medicaid assistance. An extensive search of other judicial circuits reveals a similar dearth of authority in comparable situations where regulations fail to identify a specific number of days in which to act. *See Doe, 1-13 ex rel. Doe Sr. 1-13 v. Bush*, 261 F.3d 1037, 1062 n.20 (11th Cir. 2001)("The only regulation that specifically addresses the time period for furnishing services, as opposed to determining eligibility therefor, provides only that the state agency must '[f]urnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures.' 42 C.F.R. § 435.930."); *Susan J. v. Riley*, 254 F.R.D. 439, 452, n.10 (M.D. Ala. 2008) ("With respect to furnishing services, the

Medicaid regulations do not define 'reasonable promptness' in terms of a specific time period. The regulations only state that the agency must furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures.")(internal citations and quotations omitted).

While other courts have had little difficulty in determining that delays of several years violate the reasonable promptness mandate, no court has found it necessary to transcribe a bright line rule for defining reasonable promptness in regard to the provision of services or equipment to individuals previously found eligible for Medicaid. *See Doe 1-13 By & Through Doe, Sr. 1-13 v. Chiles*, 136 F.3d 709, 717 (11th Cir. 1998)("While there may be a range of reasonable time periods for provision of assistance, there certainly are *some* time periods outside that range that no State could ever find to be reasonable under the Medicaid Act.")(cleaned up); *Boulet v. Cellucci*, 107 F. Supp. 2d 61, 72 (D. Mass. 2000)("Certain periods of time, like the three to ten or more years plaintiffs have been waiting, are far outside of the realm of reasonableness—a conclusion which a court is perfectly capable of reaching.")(internal quotation omitted).

As was the case in *Doe II*, Plaintiffs here contend that DHHS has a firm 90-day window to provide or fully deny services or equipment once requested.[43] Conversely, Defendant argues this rigid deadline belies the term "reasonable promptness" and should

[43] Although Plaintiffs advocate for a firm 90-day period, they do concede that certain "reasonable" delays may be taken into account. However, they aver that any delay over 90 days should be explained in a formal written notice.

not be used as the standard for providing services. Defendant would instead have us apply a more lenient standard such as the general rule stated in 42 C.F.R. § 435.930 that directs services should be provided "without any delay caused by the agency's administrative procedures."

Because the Fourth Circuit has expressly declined to determine which regulation is applicable to the provision of equipment or services or otherwise address the "more subtle issues of timeliness," the Court must do so here in the first instance.[44]

Accordingly, this Court holds that DHHS should strive to provide equipment and services, or an adequate formal denial thereof, in 90 days. Any provision of equipment, services, or adequate notification of denial[45] within 90 days will be presumed to be reasonably prompt and therefore comply with § 1396a(a)(8)'s reasonable promptness mandate. However, any failure to provide services or equipment within 90 days will not violate the reasonable promptness mandate if DHHS can show that any such delay was not caused by the agency's

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[44] Additionally, as stated above, ALJ's and state hearing officers have expressly declined to consider these broader constitutional issues such as reasonable promptness.

[45] This denial references a written denial complying with 42 C.F.R. § 431.210 which provides a recipient with notice of the right to appeal to the fair hearing division. The timeliness of such an appeal is provided for elsewhere in the state's Medicaid manual. *See* 42 C.F.R. § 431.244(f); State Medicaid Manual § 2903.3.

administrative procedures[46] or is otherwise excusable. Each request must be examined on a case-by-case, fact specific basis to determine whether DHHS acted with reasonable promptness.

This 90-day reasonableness period is supported by the general use of 90-day periods elsewhere in Medicaid regulations. *See* 42 C.F.R. § 435.912 (determination of eligibility within 90 days); 42 C.F.R. § 431.221(allowing applicants "a reasonable time, not to exceed 90 days" to request a hearing); 42 C.F.R. § 431.244 (hearing decisions must be provided ordinarily within 90 days); *see also Boulet v. Cellucci*, 107 F. Supp. 2d 61, 73 (D. Mass. 2000)("Another regulation provides that a state's time standards for determining applicants' eligibility may not exceed ninety days for applicants who apply to Medicaid on the basis of disability. 42 C.F.R. § 435.911. While this regulation is focused on eligibility determinations rather than the actual provision of services, it still gives some guidance to courts attempting to decide what time periods may be considered reasonably prompt in the larger context.").

Additionally, the Fourth Circuit has generally cited to these 90-day provisions when discussing reasonable promptness. *See Doe I*, at 356 ("the relevant federal and state regulations and manuals define reasonable promptness as forty-five days or ninety days, depending on the applicant"); *see also*

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[46] For instance, delays caused solely by the provider such as a delay in submitting a request for payment once all information is received or a delay caused by a provider's need to procure the equipment requested once approved by Medicaid may not be attributed to DHHS and included in the presumptive 90-day calculation.

Doe 1-13 By & Through Doe, Sr. 1-13 v. Chiles, 136 F.3d 709, 717 (11th Cir. 1998)(upholding a 90-day deadline for the state agency to determine eligibility for Medicaid recipients' requests to be placed into certain care facilities.); *Susan J. v. Riley*, 254 F.R.D. 439, 452, n.10 (M.D. Ala. 2008)("Courts considering the issue have found that 'reasonable promptness' means within ninety days.")

However, strict compliance with this 90-day goal would render the term "reasonable promptness" meaningless. If the drafters of these regulations intended for each request to be fulfilled within 90 days, they simply could have stated as such, just as they did elsewhere within the various regulations discussed above. However, these regulations are silent as to a specific number of days when providing equipment or services. Moreover, the regulations state that the agency must "furnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures." 42 C.F.R. § 435.930. The application of a strict 90-day window would render this regulation superfluous as well. Accordingly, the Court finds that the presumptive 90-day guideline expounded above to achieve the goals of providing benefits promptly, while giving credence to the language of the relevant regulations.

Although the above mandate provides a helpful first step in determining reasonable promptness, the full calculus used to determine the applicable timeline is still uncertain. Specifically, that date on which the clock starts is subject to great debate. Plaintiffs here advocate that the time for reasonable promptness should begin the day a plan of care, or subsequent change order, is approved by the WAD.

Under this position, any item of medical equipment or request for a change in services listed as a need in the care plan would be due 90 days from the date the plan of care is approved.

The Court finds this suggestion untenable for several reasons. Such a proposition would work an unreasonable hardship on DHHS and its agencies—especially case managers. For instance, case managers testified that care plans would often include needs such as routine maintenance of wheelchairs or lifts to allow for faster service if a problem arose in the future. To mandate such a service be provided in 90 days would cause a case manager to order equipment prematurely or have them leave the anticipated needs off the plan altogether for fear of violating reasonable promptness.

Additionally, new "needs" as identified by caregivers are not certain to later be identified as "medically necessary" by a medical professional. This certification of medical necessity is a prerequisite to Medicaid funding. Case managers may be able to communicate with medical professionals if a recipient executes proper waivers. However, case managers have no authority to order medical professionals provide requisite documentation on a timely basis. Medical professionals may also need to perform additional evaluations, either on the recipients or existing pieces of equipment, before declaring a new piece of equipment medically necessary and drafting a proper LoN. Counting the time needed to consult with a medical professional and obtain necessary documentation against DHHS would be unreasonable given that a case manager has no control over this portion of the process.

Moreover, recipients have the freedom of choice and must therefore make their own decision as to who their preferred equipment provider will be. Accordingly, a required quote for the requested item cannot be generated until the provider is identified. Thus, even after the WAD approves a care plan, the recipient must still be the individual who identifies a provider and relays that information to the case manager. It would be unreasonable to start the clock immediately upon WAD approval when the recipient still has the right and duty to identify his chosen provider and relay that to the case manager.[47] Moreover, such providers often need to conduct in-home inspections or gather measurements prior to providing the requisite quotes. Again, the case manager can oversee this process but ultimately has no authority to force a recipient or provider into action.

Plaintiffs aver that case managers are the individuals responsible for gathering all necessary information or prompting the recipient to provide necessary information. Specifically, Plaintiffs aver that DDSN becomes aware of needs in the care plan the moment it is approved by the WAD. Plaintiffs would then have the burden for further action shifted to the case managers and make them responsible for gathering provider information and evidence of medical necessity. However, as stated above, the case managers have no authority to force recipients, providers, or medical professionals into action.

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[47] This determination does not change the fact that case managers may be asked to supply a list of providers in an effort to expedite the process.

Additionally, Plaintiffs' proposition would have the Court treat Nancy and her attorney as individuals wholly ignorant of the system and the need to acquire provider quotes and evidence of medical necessity. Nancy has years of experience requesting equipment for Richard and testified that case managers were always available to help in the process. Moreover, Nancy's attorney, Harrison, was copied on nearly every communication with case managers. Furthermore, she was present during annual assessments and even corresponded with case managers directly to suggest changes to annual assessments prior to submission to the WAD. This is the same attorney who has filed dozens of state lawsuits, federal actions, administrative appeals, and the like on behalf of Medicaid recipients. Accordingly, Plaintiffs' argument that Nancy was constantly in the dark as to what was required when requesting equipment or services lacks merit. Therefore, the Court rejects the proposition that Plaintiffs need only identify a piece of equipment as a need on the annual care plan to trigger a 90-day deadline and shift the entire burden of production to the case manager.

Thus, requiring any and all requests listed in an annual plan of care or subsequent change order to be completed within 90 days of the plan's approval is not reasonable.

Conversely, DHHS argues that the time should begin only after the recipient or his caregiver has "made an application" for equipment or services. Essentially, DHHS suggests that the time begins to run only after a recipient has provided to the case manager all information and documentation necessary for acquiring funding approval of the

device or service and the case manager then submits the packet for approval to Medicaid via Kepro. DHHS grounds this conclusion on the use of "date of application" as the triggering date in 42 C.F.R. § 435.912(c)(1).[48]

DHHS would have this "application" include documentation such as the name of the chosen provider, a quote from that provider, a prescription for the equipment, a letter of medical necessity, or an explanation of remedial benefit from a medical professional. DHHS further argues that it has no control over primary insurers, including Medicare, and therefore it should not be accountable for the time required to submit requests through Medicare. Thus, DHHS argues that an application for equipment is not made until Medicare is exhausted and proper documentation is submitted to Medicaid through Kepro. The Court finds this suggested start date too onerous as it could potentially place the entire burden on a recipient or his already taxed caregiver while allowing a case manager to sit idly by in contradiction to their intended purpose. These case managers are employed for their ability to aid in the process and should be engaged when a recipient identifies a need.

When contemplating the competing interests described above, the Court is left to balance the equities at play while attempting to square its determination with the Medicaid mandate of "reasonable promptness." Given the above, the Court

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[48] Again, this provision appears to apply only to a potential recipient's initial application for eligibility of Medicaid benefits. However, Defendant advocates for the same rationale to apply here given the lack of specific guidance for individual requests for equipment.

concludes that the time begins when the case manager has either (1) been provided with all of the necessary information and documentation requested from the recipient or caregiver, or (2) at the time the recipient or caregiver has unequivocally requested assistance in obtaining the necessary information and provided the case manager with the ability to gather that information. To clarify, the recipient or care giver must either (1) provide all documentation necessary to submit the request for payment—which would include a quote from the chosen provider and a LoN—or (2) request assistance from the case manager while also clearing the path for that case manager to move forward by: properly identifying the preferred provider; executing releases sufficient for a case manager to gather the needed documentation from medical professionals; appearing for evaluation before a medical professional or provider; or otherwise allowing a case manager to obtain the information and documentation necessary to submit a request.[49]

Of course, any delay caused by the caregiver's request to the case manager to obtain the necessary information and documentation should be taken into account when determining whether the ultimate

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[49] A combination of these two options would also be possible. For instance, a recipient's care giver could acquire and turn over a LoN from the recipient's physician while simultaneously informing the case manager of their preferred provider. Assuming no other information or evaluation was necessary, the case a manager could then contact the provider to obtain a quote which would then allow for a request to be submitted. Plaintiffs here often utilized this hybrid approach to expedite a request, and the Court anticipates such cohesion would continue to aid in the process.

provision of equipment or services was completed with reasonable promptness.

Moreover, the date the clock should stop is also unsettled. Plaintiffs here aver that the time stops when the equipment or service is ultimately provided[50] to the recipient. However, DHHS argues that the time should stop when payment for the device or service is authorized. DHHS avers that it cannot provide equipment or services itself. S.C. Code § 44-6-30(3). Equipment and services may only then be provided by third parties over which DHHS has no control—other than financial incentive. Thus, DHHS should not be held accountable for delays or other problems caused solely by these third-party providers. For instance, if payment for a personalized device was authorized for a provider located across the country, the time it takes to manufacture and ship the device after the payment has been authorized should not count against DHHS. Likewise, a delay in repairing a mechanical lift necessitated by a repair company's busy schedule or unavailable parts should not count against DHHS.

This Court agrees with Defendant's position. As a source of funding for eligible beneficiaries, DHHS cannot be held accountable for delays outside of its control. Assuming it will not cause unreasonable delays, DHHS can exert what little leverage it has by authorizing payment for a device or service, yet withhold payment until delivery is actually made. Other than that, DHHS lacks the ability to expedite or otherwise force an independent manufacturer or

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[50] If the equipment is ultimately denied, the clock would then stop upon receiving a formal written notice explaining all reasons and criteria for denial.

provider to work faster.[51] Thus, this Court concludes that DHHS has fulfilled its obligation once it has authorized payment sufficient to permit the provider to finalize provision of the equipment. Should the provider require payment prior to providing the previously approved equipment or repair service, the time stops when DHHS issues the necessary payment. This authorization of funding will not otherwise relieve a case manager from their continuing obligations to a recipient, which may include monitoring the progress of the requested equipment or service once payment is authorized and keeping the recipient reasonably informed of the same.

Having determined the appropriate start date, end date, and presumptive reasonableness period, the Court may now apply this "reasonable promptness calculus" to Richard's requests for specific pieces of equipment.

Water Walker

Richard's request for a water walker provides a prime example of the arduous journey some recipients must embark upon when requesting a relatively inexpensive piece of medical equipment. Because this endeavor also includes delays attributable to both Plaintiffs and Defendant, it serves as a worthy candidate for this Court's initial use of the reasonable promptness calculus.

Although the water walker was identified as a need in Richard's October 5, 2020 care plan, the

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[51] Of course, it may be possible to authorize funding for expedited manufacturing or shipping should the need arise, but that is a consideration not before this court.

evidence showed that the case manager did not receive all necessary documents until March 25, 2021. Because Nancy was informed of the need to gather this information and was working to obtain it, the reasonable promptness window began to run only when the information was provided to the case manager. Therefore, the delays in acquiring the LoN necessitated by Richard's emergency medical conditions and Covid-19 are not attributable to DHHS. Here, the case manager already possessed the requisite quote when Nancy had Richard's physician fax the LoN on March 25, 2021. This fax was then immediately misplaced. After realizing this error, the case manager then received the LoN after it was again faxed on April 30, 2021. The delay caused by the misplaced fax is attributable solely to the case manager and is therefore considered a delay caused by the agency's administrative procedures. Thus, the presumptive promptness period began to run on March 25, 2021—the date in which Nancy had done everything in her power to provide all necessary information to the case manager.

Once all information was received, the request for a water walker was approved in 3 days — a relatively short amount of time. However, further delays ensued due to DHHS' need to verify the provider's business license and process the board-billed payment. Although the case manager worked diligently to resolve these payment issues, the provider would not send the water walker until payment was made. DHHS ultimately issued payment by mailing a check on July 7, 2021. Because prior payment had to be issued to allow for the device to be shipped, the date of this board-billed payment serves as the termination date regardless of

when the water walker was actually received. Thus, it took 104 days for Defendant to fulfill its statutory duties. As stated above, the initial delay in getting the quote and LoN to the case manager is not included in this calculus as the clock had not yet begun to run. However, the subsequent delays caused by misplacing the faxed LoN (36 days) and generating a board-billed payment (65 days) must be attributed to the Defendant. Because the period exceeded 90 days and the delays were not justified, this Court declares that Defendant failed to provide a water walker to Richard with reasonable promptness.

Stander

As of June 27, 2018, the LoN and quotes had been provided and case managers were working with the provider to submit its funding request to Kepro. The LoN was generated on May 2, 2018 and the quote was generated on May 16, 2018. However, Plaintiffs have failed to show how or when this information was submitted to the case manager. Thus, the Court concludes the time must begin to run on the earliest date the case manager is known to have possessed the requisite information—June 27, 2018. The case manager consulted with the provider who resubmitted its request to Kepro with different coding and documentation on September 6, 2018. Kepro denied this request on September 12, 2018 and Richard was informed of this denial via letter dated September 21, 2018. Moreover, this denial letter included all statutorily required information and informed Plaintiffs of additional steps that could be taken if they disagreed with the

decision. This proper denial letter therefore serves as the termination date. Consequently, Defendant fulfilled its statutory duties in regard to the stander in 86 days by providing an adequate denial letter. Thus, its actions are presumed to have been reasonably prompt.

Although evidence shows that Nancy and Harrison requested that the case manager submit a request for reconsideration on the basis that a stander would provide some remedial benefit, case notes clearly show that Richard's Bright Start case manager had requested and was waiting on Nancy and Harrison to provide the medical documentation needed to make such a request. Richard then transferred away from Bright Start before reconsideration was ever sought or a request could be made to the wavier. Richard ultimately received the stander by way of a consent order issued after requesting a reconsideration from DHHS and filing an appeal to the fair hearing division. However, by agreeing to provide the stander in the consent order, DHHS did not concede that the reasons utilized in initially denying the stander were incorrect or otherwise improper. Thus, the delay in Richard's ultimate receipt of the stander caused by proper appeals after a timely denial letter is not attributable to DHHS in the initial reasonable promptness calculus. Thus, Plaintiffs have failed to show that DHHS was not reasonably prompt in providing a stander.

Ceiling Lift

Richard has had several repairs to his ceiling lift in recent years and each request for repair must be

handled separately. Initially, Richard's 2018 care plan states that the lift needed a new motor, and this need was completed no later than March 22, 2019. Notes in the care plan state that at that time the "lift is in fair condition and working for now." Plaintiff failed to present any evidence as to the date Nancy sought assistance from a case manager or otherwise provided the requisite quote or documentation for this repair request.[52] Thus, Plaintiffs have failed to show that DHHS was not reasonably prompt in repairing the lift motor.

Next, Plaintiffs contend that Richard's lift required an inspection and new battery. On November 17, 2020, Nancy informed the case manager that she had requested a quote. On January 8, 2021, Nancy paid for the new battery and inspection herself. There is no evidence showing that Nancy ever notified the case manager of this out-of-pocket payment. Nancy did not request reimbursement until August 10, 2021—well after the service had been provided. Accordingly, DHHS did not fail to meet the reasonable promptness mandate given that the inspection and new battery had already been provided before the case manager was informed of the repair or a request for reimbursement had been made.

On January 13, 2021, Nancy called the case manager to inform her that repairs were needed, and

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[52] It does not appear that Plaintiffs were ever required to obtain a LoN or other documentation of medical necessity prior to having these repairs authorized. This is likely due to the fact that these requests were simply for repairs to previously authorized equipment. Thus, provision of the requisite bill or invoice to the case manager serves as the triggering date for these requests.

she had received a bill. This bill showed the costs for the battery and inspection discussed above. Apparently, Nancy never informed the case manager that she had made payment because the case manager requested a new invoice on January 14, 2021 after confirming with the provider that the balance had not been paid. This request to repair was approved on January 15, 2021.

The third request for repair to the lift came on January 22, 2021, when the case manager contacted the provider to clarify new costs on an amended invoice. The case manager learned that the additional costs were attributable to the replacement of certain safety equipment on the lift. The WAD approved this amended request on January 26, 2021. That same day, the case manager notified the provider of this approval so they could begin the repairs and the case manager also notified Nancy and Harrison of the progress. Although the lift was not fully repaired until March 26, 2021, DHHS fulfilled its statutory duty of reasonable promptness on January 26, 2021, when the repairs were approved and the provider notified.[53] Thus, the evidence presented by Plaintiffs show that the case manager first received the necessary quote on January 13, 2021, with an amended quote arriving on January 22, 2021. Therefore, DHHS fulfilled its duty of approving the repair requests within 13 days. Even if the Court were to use the actual repair date as the end date, the lift was fully repaired by March 26, 2021— 72 days after receiving the initial bill from Nancy. Because this period falls within the

[53] Notes show that delays after this date were attributable to the provider as they had to order parts and wait for them to be shipped prior to performing the repair work.

presumptive 90-day window, DHHS is declared to have acted with reasonable promptness as to the various repairs on Richard's lift.

Although Plaintiffs further contend that bills for these repairs were sent to Kershaw and remain unpaid, there is no dispute that the repairs have already been made. Accordingly, any delay in payment from Kershaw, either to the provider or to Nancy's untimely request for reimbursement, are irrelevant given that the repairs were performed with reasonable promptness.

Gait Trainer

The need for a new gait trainer was identified in Richard's October 5, 2020 care plan. Although Richard's October 8, 2019 care plan[54] also identifies the need for a gait trainer, there is no evidence Plaintiffs attempted to pursue a request for a gait trainer until November 17, 2020, when Nancy reached out to her chosen provider for quotes on a new gait trainer. The case manager informed Nancy on the same day that medical justification would also be needed. The case manager received this medical justification on December 4, 2020 and the quote on December 14, 2020. Thus, the reasonableness period for the gait trainer began to run on December 14, 2020. The provider confirmed that Kepro approved payment of the gait trainer no later than January 13, 2021. The gait trainer was delivered on February

[54] Although Richard's January 16, 2012 care plan identifies the need for a gait trainer, his October 2018 care plan does not identify the need for a gait trainer. Evidence at trial indicated that he received a gait trainer in 2014 that needed to be replaced in 2019.

16, 2021. Thus, the reasonableness period began on December 14, 2020 and ended when payment was approved on January 13, 2021, resulting in a time of 30 days. Thus, DHHS was reasonably prompt in approving Richard's request for a gait trainer.

Ankle Foot Orthoses

Although AFOs were not listed in Richard's October 2018 care plan, Nancy discussed the need for new AFOs with the case manager in March 2019. That Bright Start case manager sent a list of providers to Nancy on March 27, 2019. Plaintiffs presented no evidence that they chose a provider or otherwise pursued a request for AFOs while at Bright Start or once Richard transferred to Oconee. After AFOs were again noted in Richard's October 5, 2020 care plan, the case manager received medical justification and the provider's information on December 4, 2020. However, Nancy was attempting to get a quote and had not received one as of January 22, 2021. There is no indication of when a quote was ever received. The AFOs were ultimately received on March 24, 2021. There is no indication of when payment for the AFOs was authorized, but the case manager did confirm with the provider on March 24, 2021, that payment for the AFOs would be covered by Medicaid. Moreover, on March 24, 2021, Nancy informed the case manager that there had been a delay in getting Richard's AFOs due to Richard's recent health concerns. Although there is no evidence as to when Plaintiffs received the necessary quote, if this Court were to assume that the quote was received on January 22, 2021 (the same day Nancy stated she had yet to receive a

quote), the reasonableness period would run from January 22, 2021 to March 24, 2021, at the latest, for a period of 61 days.[55] Thus, Defendant provided AFOs with reasonable promptness.

Door Opener

Nancy first requested help with repairing Richard's existing door opener on March 21, 2019 from the Bright Start case manager. Although the case manager initially reported that Nancy's chosen provider, NSM, did not provide door openers, Nancy later learned that they could provide the necessary service from their Charlotte office. The Bright Start case manager made arrangements for an NSM agent to inspect Richard's door opener and provide a quote, but Richard transferred away from Bright Start before the inspection. Plaintiffs provided no evidence of efforts made to repair the door opener while at Oconee. The door opener was noted as a need on Richard's October 5, 2020 care plan and Nancy informed the case manager on November 17, 2020 that she had requested a quote from the provider. The provider needed to inspect the door opener prior to providing a quote which was then submitted to

[55] Even if this Court were to begin the reasonableness period on December 4, 2020 (the day the case manager received medical justification and provider information) and end it on the day Richard received his AFOs, only 110 days had elapsed. A portion of this delay was caused by Richard's health concerns. Because Plaintiffs have the burden of proof and failed to show how much of the delay was attributable to DHHS' administrative procedures, Plaintiffs have failed to carry its burden of showing that the excess 20 days are attributable solely to DHHS. Thus, Plaintiffs' claims would fail regardless of the triggering date used.

the case manager on January 7, 2021.[56] The case manager submitted a change request and had the request approved on the same day. The case manager then notified the provider that the repairs could be made. The door opener was installed January 29, 2021. This request was approved the same day the quote was received and was therefore reasonably prompt.[57]

Catheter Supplies

Although Plaintiffs argued that Richard is in danger of losing funding for certain tubing needed for his catheters, evidence showed that Richard has never gone without his necessary tubing and further temporary funding would be approved through the wavier until the Medicaid/Medicare funding issue was resolved. Thus, Plaintiffs have failed to show any improper action or inaction regarding the catheters. Moreover, Plaintiffs' proposed findings of fact is completely silent as to catheters. Thus, Plaintiffs have failed to support any claim arising from funding for catheter supplies.

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[56] It does not appear that Plaintiffs were ever required to obtain a LoN or other documentation of medical necessity prior to having this replacement authorized. This is likely due to the fact that these requests were for a replacement of a previously authorized device. Thus, provision of the requisite quote to the case manager serves as the triggering date for these requests.

[57] Even if the Court were to calculate the time period from the earliest date the case manager knew Nancy had requested a quote to the day it was repaired, only 73 days had elapsed.

Wheelchair

Richard's most recent wheelchair was funded through Medicare and delivered on December 11, 2019. As of March 22, 2019, Richard had been fitted for a new wheelchair. Notes dated May 2, 2019 indicate that Medicare approved funding for the wheelchair, but not a seat height adjustment accessory. The case manager then submitted a request for funding of the accessory via the ID/RD wavier which was approved on May 6, 2019—just 4 days after waiver funding was requested. Plaintiffs presented no evidence as to the cause of delay between the May 2019 approvals and the December 11, 2019 delivery. Additionally, there is no evidence of when or if quotes or medical documentation were provided to the case manager. Thus, Plaintiffs have failed to present evidence showing DHHS was not reasonably prompt in the provision of Richard's wheelchair or accessories. Even if this Court were to assume that the case manager had all necessary information by March 22, 2019 (the date Richard had been fitted for a new wheelchair), and utilized this date as the triggering date, funding for both the wheelchair and accessory were fully approved by May 6, 2019—just 45 days later. Accordingly, approval for the wheelchair and accessory was provided with reasonable promptness.

The above determinations adjudicate Plaintiffs' claims asserting violations of the reasonable promptness mandate of 42 U.S.C. § 1396a(a)(8). Although reasonable promptness served as the gravamen of Plaintiffs' case, the Court's inquiry does not end there given the plethora of other statutory

provisions Plaintiffs seek to enforce by way of a § 1983 claim.

Fair Hearing: 42 U.S.C. § 1396a(a)(3)

Plaintiffs also assert that DHHS violated 42 U.S.C. § 1396a(a)(3) which states that the state agency responsible for Medicaid state plan must "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." Plaintiffs failed to present evidence that they were ever denied a fair hearing. To the contrary, DHHS provided Plaintiffs with a notice of their right to a fair hearing in the one instance where a piece of equipment was denied. When noting that a request for a stander was denied, DHHS' letter stated that: "If the service is denied again you will have the option to contact the SCDHHS Division of Appeals and Hearings and request a State Fair Hearing to appeal the decision. The denial notice that you receive after the reconsideration will explain the process to request a State Fair Hearing." Indeed, Plaintiffs later requested a reconsideration and promptly proceeded to appeal to the fair hearing division once the reconsideration request was denied. That appeal resulted in a consent order providing the stander. Thus, a fair hearing was provided in accordance with the statute. Consequently, Plaintiffs' claims arising out of this statutory provision must fail.

Amount Duration and Scope: 42 U.S.C. § 1396a(a)(10)

Next, Plaintiffs assert that Defendant violated the amount duration and scope requirement found in 42 U.S.C. § 1396a(a)(10). This provision mandates that medical assistance to qualified individuals shall not be less in amount, duration, or scope than the medical assistance made available to other individuals. Plaintiffs made no reference or argument to this statutory provision during trial and therefore have failed to meet their burden in showing such a provision was violated. Therefore, any claims arising out of this provision likewise fail. As an aside, it appears that this provision would be applicable only to Plaintiffs' request for nursing hours, which has been found to be moot, and not to Plaintiffs' request for medical equipment.

Reasonable Standards: 42 U.S.C. § 1396a(a)(17)

Next, Plaintiffs assert that Defendant violated 42 U.S.C. § 1396a(a)(17) which mandates that the state entity must promulgate reasonable standards for determining eligibility for and the extent of medical assistance under Medicaid which are consistent with the objectives of the Medicaid program. However, the Court agrees with Defendant's proposition that there is no private cause of action under § 1983 for a violation of 42 U.S.C. § 1396a(a)(17). *Davis v. Shah*, 821 F.3d 231, 244 (2d Cir. 2016) ("Because the Medicaid Act's reasonable standards provision addresses a state's general administrative duties under the Act, rather than defining individual beneficiaries' entitlements

under that program, it does not appear to contain the type of rights-creating language necessary to confer a private cause of action."); *Hobbs ex rel. Hobbs v. Zenderman*, 579 F.3d 1171, 1182 (10th Cir. 2009); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006); *Watson v. Weeks*, 436 F.3d 1152, 1162 (9th Cir. 2006).

Even if Plaintiffs possessed a private cause of action to enforce 42 U.S.C. § 1396a(a)(17), Plaintiffs have still failed to show how a failure to promulgate reasonable standards resulted in any injury here. As stated above, Plaintiffs had unfettered access to their case managers who provided information and guidance throughout their various requests. Moreover, these case managers testified that they had access to DHHS and DDSN agents and decision makers should the need for additional information or clarification arise. Plaintiffs failed to show how additional written reasonable standards would have advanced their cause or otherwise aided in their requests. Although Plaintiffs did argue that access to the computer program Therap would allow them to closer monitor requests, they failed to show how the same information could not be garnered by simply calling their case manager. Accordingly, Plaintiffs presented no evidence that the lack of access to this program resulted in an injury to Richard or a future injury needed for declaratory and injunctive relief. *Kenny v. Wilson*, 885 F.3d 280, 287 (4th Cir. 2018)([B]ecause plaintiffs here seek declaratory and injunctive relief, they must establish an ongoing or future injury in fact".) Thus, Plaintiffs' claims arising out of 42 U.S.C. § 1396a(a)(17) must fail.

Feasible Alternatives: 42 U.S.C. § 1396n(c)(2)

Next, Plaintiffs' complaint asserted violations of 42 U.S.C. § 1396n(c)(2) which mandates that the state assures that "such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the [intellectually disabled] are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the [intellectually disabled]." On its face, this provision applies only to Plaintiffs' now mooted claims regarding nursing hours and not the provision of medical equipment. Thus, any claims based on this statutory provision must fail. Again, even if this section were applicable to medical equipment, Plaintiffs have failed to show what reasonable alternatives may have existed or that Richard was entitled to be informed of them.

The Rehabilitation Act

The Court now turns to Plaintiff's remaining claims of violations of § 504 of the Rehabilitation Act. Within their proposed conclusions of law, Plaintiffs summarily state that:

> Plaintiff Stogsdill is entitled to relief under § 504 of the Rehabilitation Act because he has shown (1) he is an individual with a disability; (2) he is otherwise qualified to receive the benefit; (3) he was denied the benefits of the program solely by reason of

> his disability; (4) the program receives federal financial assistance, and he has requested reasonable modifications to the DHHS/DDSN programs so that (1) DHHS should be directed to require DDSN to provide Stogsdill access to Therap, DHHS should be required to provide written notices compliant with 42 C.F.R. 431.210 when needed services are denied, reduced, suspended or not provided within 90 days.

Plaintiffs provide no other support for this argument. Despite Plaintiffs' assertions, they have failed to present any evidence that Richard was denied benefits of the program solely by reason of his disability. As stated above, DHHS' only failure to comply with reasonable promptness was in regard to the water walker. Moreover, those delays, although attributable to DHHS, were caused by a misplaced fax and failure to timely issue a check to an out-of-state provider. At no point did Plaintiffs present any evidence or argument that Richard was discriminated against because of his disability. At no point did Plaintiffs argue that Richard's risk of institutionalization increased because of a failure to provide the requested equipment. Accordingly, Plaintiffs have failed to show a violation of § 504.

Although Plaintiffs again request that this Court mandate they have access to Therap, Plaintiffs have failed to show how this access would aid in the process or otherwise provide information readily available via their case managers. Additionally, Plaintiffs have failed to show why DHHS should be ordered to provide written notices compliant with 42 C.F.R. 431.210 when needed services are not

provided within 90 days. As evidenced above, the only denial DHHS issued complied with 42 C.F.R. 431.210.[58] Moreover, applicable regulations only mandate such a written notice in certain situations including the denial, termination, or reduction of an individual's claim for benefits or services. 42 C.F.R. § 431.206; 42 C.F.R. 431.201. There is no indication that such a notice is likewise mandated for a failure to provide equipment within 90 days. The Court declines the invitation to read in such a mandate to otherwise silent regulations now. Again, case managers conduct status calls with Nancy at least monthly. Any delay in a request for equipment can be explained in these frequent communications.

As an aside, Plaintiffs presented evidence that a recipient may be able to request a fair hearing when a "request for benefits has not been made in a timely manner." (ECF No. 469, p. 2). Indeed, 42 C.F.R. § 431.200 mandates that a recipient be provided an opportunity for a fair hearing when "a claim for assistance is denied or *not acted upon promptly*." (emphasis added); *see also* 42 C.F.R. § 431.220(a)(1). Accordingly, Plaintiffs are free to request a fair hearing should they feel Richard's requests are not being processed in a timely manner. Of course, DHHS may avoid the risk of such a fair hearing request by complying with the 90-day presumptive reasonableness period as set forth above.[59]

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[58] This regulation requires a notice to contain: a statement of what action will be taken; a statement of the reasons supporting the action; the specific regulations supporting that action; and an explanation of the recipients right to a hearing. 42 C.F.R. § 431.210.

[59] Although these fair hearing officers and administrative law judges have refused to issue a ruling on constitutional claims,

Although previously barred by preclusion principles, the above determinations as to § 504 of the Rehabilitation Act would apply equally to Plaintiffs' claims under the ADA because these two provisions impose the same integration mandate. *Pashby v. Delia,* 709 F.3d 307, 321(4th Cir. 2013) ("We consider their Title II [of the ADA] and section 504 claims together because these provisions impose the same integration requirements.").

Accordingly, other than the singular declaration regarding DHHS's failure to provide the water walker with reasonable promptness, Plaintiffs have failed to carry their burden of proof in regard to all other claims. To the extent that any remaining claim is not specifically addressed above, the Court finds that those remaining claims likewise fail as Plaintiffs have failed to provide sufficient evidence which would warrant the relief sought.

Consequently, the Court declines to issue any prospective injunctive relief. *See Kenny v. Wilson*, 885 F.3d 280, 287-88 (4th Cir. 2018) (stating to prevail in an action for prospective injunctive relief, plaintiffs must establish an ongoing or future injury in fact) *citing O'Shea v. Littleton*, 414 U.S. 488, 495-96 (1974) ("Past exposure to illegal conduct does not in itself show a present case or controversy regarding injunctive relief . . . if unaccompanied by any continuing, present adverse effects."). Having elucidated the reasonable promptness calculus, the Court has clarified Defendant's obligations in providing medical equipment to qualified recipients once properly requested. Given that DHHS was, and

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they remain able to determine whether a recipient it entitled to a certain piece of equipment and whether that piece of equipment has been approved in a timely fashion.

continues to be, bound by applicable Medicaid statutes and regulations, including the reasonable promptness mandate, ordering DHHS to process Richard's future requests in a reasonably prompt manner would serve no useful purpose and be completely superfluous. Because Plaintiffs have expressly declined to seek any monetary damages, the declaratory relief described above remains their sole award in this action.

As noted by other Judges in this district, the State of South Carolina's administration of the Medicaid system is far from perfect. *Timpson by & through Timpson v. McMaster*, 437 F. Supp. 3d 469, 472 (D.S.C. 2020) ("Make no mistake about it, the disability system in South Carolina is broken and is in need of repair. Programs are underfunded. Waitlists are long. And patients are not adequately informed about the programs for which they qualify."). Defendant here admits that the system is not beyond reproach. Furthermore, the Court does not doubt the seriousness of Richard's ever-evolving needs for medical equipment, nor does it seek to downplay the potential hardships caused by administrative red tape. However, not every delay or procedural requirement results in a violation of Richard's federal rights.

Plaintiffs here have inundated the Court with irrelevant exhibits, amorphous and shifting arguments, and scattered references to various cases, statutes, and regulations. Despite this years long saga, Plaintiffs have again failed to prove a vast majority of their claims. Moreover, the relief which was granted could have been supported with a handful of exhibits and limited testimony. Instead, Plaintiffs' counsel flooded the Court with thousands

of irrelevant documents, numerous immaterial witnesses, and specious legal arguments.

Despite this protracted litigation, and through final resolution thereof, this Court seeks to have provided some clarity and guidance for all parties moving forward in hopes to avoid further unnecessary and prolonged litigation.

IV. CONCLUSION

For all the reasons stated above, Plaintiffs' request for declaratory relief is granted as to the reasonable promptness determination regarding the untimely provision of Richard's water walker. All other requests for relief are denied.

IT IS SO ORDERED.

October 5, 2021

/s/ Joseph F. Anderson, Jr.
Columbia, South Carolina
United States District Judge

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

BEFORE THE DIVISION OF APPEALS
AND HEARINGS
SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

C.A. No.: 21-1608

Richard Stogsdill,
Petitioner,
v.

South Carolina Department of Health and Human Services,
Respondent.

CONSENT ORDER

JURISDICTION

This case is adjudicated under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (DHHS) to administer various programs and grants. See e.g. S.C. Code Ann. Section 44-6-10 (2002) et seq. This appeal has been conducted pursuant to the provisions of the Appeals and Hearing regulations of the DHHS and the South Carolina Administrative Procedures Act. S.C. Code Ann. Regs. 126-150 (2011) et seq.; S.C. Code Ann. Section 1-23-210 (2005 and Supp. 2016) et seq. Richard Stogsdi11 is referred to herein as the "Petitioner," DHHS is referred to herein as the

"Respondent" or "DHHS" and the South Carolina Department of Disabilities and Special Needs is referred to herein as "DDSN."

STATEMENT OF THE CASE

At trial in the United States District Court for the District of South Carolina on July 8, 2021 at Case No. 3:12-cv-0009-JF-A, DDSN witness, Jennifer Jaques, testified that payment for the tubes necessary to connect Petitioner's condom catheter to leg bags had been denied because the provider submitted the claim to DHHS using the wrong code, and that DIDIS was responsible for payment for those supplies. She testified that if the provider resubmitted the form to DHHS using the correct code, payment would be made for the tubes.

Petitioner filed this appeal on August 14, 2021 alleging DDSN and DHHS failed to provide catheter supplies with reasonable promptness and failed to provide written notice to the Petitioner of the discontinuation of payment for tubes, in violation of 42 C.F .R. 431.210, which requires written notice stating the reasons for the termination/reduction/ failure to provide this needed equipment.

On August 18, 2021, the DHHS Division of Appeals and Hearings sent a letter to Petitioner, instructing him to provide a copy of the notice of denial by September 20, 2021. The letter instructed Petitioner that he must file an appeal or request for reconsideration through DDSN before filing an appeal with DHHS. The letter also requested additional information in support of the allegation that DDSN/DHHS has failed to take timely action.

Petitioner responded on September 8, 2021 by informing the Division of Appeals and Hearings and the director of DDSN that, in addition to tubes being discontinued without prior written notice, Petitioner's counsel had learned that payment for other catheter supplies had also been terminated earlier in the year by DDSN without prior notice. Petitioner complained in this supplemental filing that waiver participants' due process rights are violated, because they are not allowed to file an appeal until the provider files an appeal through DHHS' agent KePro, and the provider's appeal is fully adjudicated.

On September 17, 2021, while this appeal was pending, DDSN sent a "notice of reduction/denial" via Therap, the web-based program DDSN uses to record communications between DDSN, the case manager and providers, to Petitioner's case manager, after payment for the supplies at issue in this appeal had been terminated. The notice DDSN sent to the case manager provided a different reason for tenninating payment for these supplies:

> DDSN has not received sufficient documentation to include, Medicaid denials and appeals, to rule out State Plan Medicaid as a funding source for these supplies. DDSN is unable to make a decision until additional documentation is submitted. The request is being closed without changes at this time. Notice of reduction/denial sent to CM via S-COMM on 9/17/21.

Also on September 17, 2021, Petitioner's case manager, for the first time, sent a notice of reduction

of services for specialized medical equipment and supplies, with an effective date of September 15, 2021, despite DDSN terminating payment for these supplies months before. The reason provided for the reduction on the September 17, 2021 notice was "[s]ervice available through State Plan Medicaid as funding source for these supplies. DDSN is unable to make a decision until additional documentation is supplied."

On September 20, 2021, the Division of Appeals and Hearings assigned this appeal to Hearing Officer Alexander Shissias. On September 21, 2021, a prehearing conference order was issued, requiring consultation and the submission of a prehearing conference report by October 12, 2021.

FINDINGS OF FACT

The parties agree to the following findings of fact:

1. Incontinence supplies, including condom catheters, leg bags, tubes and posey devices which are medically necessary have been included in Petitioner's approved annual Support Plans and they have been funded for a number of years by DDSN through the Intellectual Disabilities/Related Disabi1ities Medicaid Waiver (IDIRD Waiver).

2. Hawthorne Medical is Petitioner's provider of choice of incontinence supplies which has historically provided these supplies.

3. DDSN, case managers and providers communicate through Therap, a web-based

documentation and communication software program and Petitioner has requested access to Therap to stay informed of communications related to his requests for services.

4. DDSN witness Jennifer Jaques testified on July 8, 2021 in the South Carolina Federal District Court that DHHS was responsible for payment of the costs of Petitioner's incontinence supplies and that payment had not been made because the provider submitted the requests to DHHS using the wrong code.

5. Ms. Jaques informed the Court that if the claims were resubmitted using the right code, DHHS would pay them.

6. 42 C.P.R. 431.211 requires the State to provide at least ten days' notice in writing prior to terminating any Medicaid service.

7. 42 C.P.R. 431.210 requires that the written notice must include a description of the action that the state intends to take, the reasons for the intended action, the specific regulations that support the action, and an explanation of the individual's right to request an evidentiary hearing and the circumstances under which the service will be continued if a hearing is requested.

8. 42 C.F.R. 431.231 requires that the services must be reinstated and continued until a decision is rendered after a hearing when the action was taken without advance notice.

9. 42 C.F.R. 431.223 allows dismissal of a request for a hearing only if the applicant or recipient withdraws the request in writing; or the applicant or recipient fails to appear at a scheduled hearing without good cause.

10. DDSN discontinued payment for certain incontinence supplies without providing Petitioner the written notice as set forth at 42 C.P.R. 431.210.

11. Petitioner timely appealed the termination of payment for these supplies .

12. DHHS policies currently require that only a provider can appeal its decisions (made through KePro) to deny payment for medical equipment and supplies, but current policies do not allow a Medicaid participant to file an appeal.

13. DDSN policies instruct case managers to provide written notices when services are reduced, suspended or terminated or when a request for services is denied, but those policies do not have written notice requirements for issues relating to reasonable promptness.

14. DDSN has not ruled upon Petitioner's request to have access to Therap, which would allow Petitioner to monitor the status of his requests for services and to have notice of additional information needed to approve a service.

SETTLEMENT

Petitioner and Respondent have agreed to settlement of this appeal as follows:

1. DDSN and DHHS agree that DDSN shall continue to pay for all incontinence supplies as previously provided through the ID/RD Waiver by DDSN unless and until DHHS assumes responsibility for payment of the cost of these supplies, without intem.1ption of these services.

2. DDSN shall reimburse Hawthorne for supplies contained in Petitioner's approved 2020 Support Plan not previously paid for within 30 days of this order.

3. Hearing Officers do not have the authority to order DDSN or DHHS to change their policies related to the provision of written notices.

4. DDSN and DHHS agree that all services identified in Petitioner's approved 2020 Support Plan will be provided and will not be discontinued, suspended or terminated without prior written notice and an opportunity for a fair hearing.

5. The provider has submitted claims to Medicare, which only covers two of the required 15 catheters, posey straps, tubes and leg bags.

6. The IDIRD waiver does not pay for items covered by Medicare.

7. DDSN has not ruled upon Petitioner's request for access to Therap and this hearing officer does not have jurisdiction to order DDSN to change its policies.

8. The jurisdiction of DHHS hearing officers is limited to appeals regarding the termination, suspension or denial of services, but hearing officers do not have jurisdiction over claims of violations of due process, other provisions of the Medicaid Act, or the Americans with Disabilities Act or the Rehabilitation Act. Specifically, DHHS hearing officers do not have jurisdiction over claims alleging violations of the due process or reasonable promptness provisions contained in the Medicaid Act.

9. This Settlement Agreement fully resolves Petitioner's appeal of the termination of services before the Division of Appeals and Hearings, without any prejudice to Petitioner's claims pending in the federal court.

10. Upon execution of this consent order, Petitioner will have received all relief which may be granted by this hearing officer, without prejudice to Petitioner's right to raise or continue litigation involving issues not resolved in this order in any other forum and without requiring Petitioner to exhaust administrative remedies, including actions brought in state or federal courts.

11. Nothing herein shall prevent the Petitioner from seeking additional state-funded services provided by the South Carolina Department of Disabilities and

Special Needs (SCDDSN) pursuant to the South Carolina Family Support Act.

12. This agreement is for settlement purposes only and is not a concession by either party of the likelihood of success in this matter or in relation to any pending action.

13. Each appeal to DHHS must be applied to its own facts and law.

CONCLUSIONS OF LAW

1. S.C. Code Regs. Section 126-154 (2011) provides that a hearing officer has the authority, among other things to direct all procedures; issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or proposed findings of fact and conclusions of law; call witnesses and cross-examine any witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with requirements under this Subarticle

2. S.C. Code Regs. Section 126-399 provides that when the requirements of the State and the Federal regulations are not in agreement, the requirements of the Federal regulations shall prevail.

3. S.C. Code Regs. Section 126~380(a) requires that when an individual's Medicaid benefits are denied, discontinued or changed, the individual must receive notice pursuant to Title XIX of the Social Security Act which must include an explanation of the

individual's right to a fair hearing, the method to obtain a hearing, and the right to representation.

4. S.C. Code Regs. Section 126-380(a) requires that fair hearings shall be conducted pursuant to S.C. Code Regs. Section 126-150, and an individual's Medicaid benefits may be continued pending a fair hearing decision in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

5. 42 C.F.R. 431.211 requires the State to provide at least ten days notice in writing prior to terminating a Medicaid service.

6. 42 C.P.R. 431.210 requires the written notice to include a description of the action that the state intends to take, the reasons for the intended action, the specific regulations that support the action and an explanation of the individual's right to request an evidentiary hearing and the circumstances under which the service will be continued if a hearing is requested.

7. 42 C.P.R. 431.231 requires the state to reinstate and continue services until a decision is rendered when action is taken without advance notice.

8. 42 C.F.R. 431.246 requires the agency to promptly make corrective payments, retroactive to the date an incorrect action was taken.

IT IS ORDERED:

1. I conclude that I have the authority to end this matter, and the agreement as stated above is fair and equitable.

2. DDSN and DHHS agree that DDSN shall continue to pay for all incontinence supplies as previously provided through the ID/RD Waiver by DDSN unless and until DHHS assumes responsibility for payment of the cost of these supplies, without interruption of these services.

3. DDSN shall reimburse Hawthorne for supplies contained in Petitioner's approved 2020 Support Plan not previously paid for within 30 days of this order.

4. Hearing Officers do not have the authority to order DDSN or DHHS to change their policies related to the provision of written notices.

5. DDSN and DHHS agree that all services identified in Petitioner's approved 2020 Support Plan will be provided and will not be discontinued, suspended or terminated without prior written notice and an opportunity for a fair hearing.

6. The provider has submitted claims to Medicare, which only covers two of the required 15 catheters, posey straps, tubes and leg bags.

7. The IDIRD waiver does not pay for items covered by Medicare.

8. DDSN has not ruled upon Petitioner's request for access to Therap and this hearing officer does not have jurisdiction to order DDSN to change its policies.

9. The jurisdiction of DHHS hearing officers is limited to appeals regarding the termination, suspension or denial of services, but hearing officers do not have jurisdiction over claims of violations of due process, other provisions of the Medicaid Act, or the Americans with Disabilities Act or the Rehabilitation Act. Specifically, DHHS hearing officers do not have jurisdiction over claims alleging violations of the due process or reasonable promptness provisions contained in the Medicaid Act.

10. This Settlement Agreement fully resolves Petitioner's appeal of the termination of services before the Division of Appeals and Hearings, without any prejudice to Petitioner's claims pending in the federal court.

11. Upon execution of this consent order Petitioner will have received all relief which may be granted by *this* hearing officer, without prejudice to Petitioner's right to raise or continue litigation involving issues not resolved in this order in any other forum and without requiring Petitioner to exhaust administrative remedies, including actions brought in state or federal courts.

12. Nothing herein shall prevent the Petitioner from seeking additional state-funded services provided by

the DDSN pursuant to the South Carolina Family Support Act.

13. This agreement is for settlement purposes only and is not a concession by either party of the likelihood of success in this matter or in relation to any pending action.

14. Each appeal to DHHS must be applied to its own facts and law.

Dated: October 8, 2021

/s/ Alexander Shissias
Hearing Officer
SCDHHS Division of Appeals & Hearings

WE CONSENT:

s/Patricia Logan Harrison
Patricia Logan Harrison
Attorney for Petitioner
Dated: October 8, 2021

/s/Nicole Wetherton
Attorney for Respondent
Dated: October 8, 2021

Rehabilitation Act

29 U.S.C. § 701. Findings; purpose; policy

(a) Findings. Congress finds that—
(1) millions of Americans have one or more physical or mental disabilities and the number of Americans with such disabilities is increasing;
(2) individuals with disabilities constitute one of the most disadvantaged groups in society;
(3) disability is a natural part of the human experience and in no way diminishes the right of individuals to—
(A) live independently;
(B) enjoy self-determination;
(C) make choices;
(D) contribute to society;
(E) pursue meaningful careers; and
(F) enjoy full inclusion and integration in the economic, political, social, cultural, and educational mainstream of American society...
(5) individuals with disabilities continually encounter various forms of discrimination in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and public services;
(6) the goals of the Nation properly include the goal of providing individuals with disabilities with the tools necessary to—
(A) make informed choices and decisions; and
(B) achieve equality of opportunity, full inclusion and integration in society, employment, independent living, and economic and social self-sufficiency, for such individuals...

Civil Rights Act

42 U.S.C. § 1983. Civil action for deprivation of rights

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State...subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress...

42 U.S.C. § 1988. Proceedings in vindication of civil rights

...

(b) Attorney's fees. In any action or proceeding to enforce a provision of sections...[42 USCS §§ 1981–1983... the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs...

(c) Expert fees. In awarding an attorney's fee under subsection (b) in any action or proceeding to enforce a provision of sections 1977 or 1977A of the Revised Statutes [42 USCS §§ 1981 or 1981a], the court, in its discretion, may include expert fees as part of the attorney's fee.

Medicaid Act

42 U.S.C. § 1396a. State plans for medical assistance

(a) Contents. A State plan for medical assistance must—...

(3) provide for granting an opportunity for a fair

hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;...
(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;...
(23) ...provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services...

42 U.S.C. § 1396n. Compliance with State plan and payment provisions

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—
(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

Americans with Disabilities Act

42 U.S.C. § 12101. Findings and purpose

(a) Findings. The Congress finds that—
(1) physical or mental disabilities in no way diminish

a person's right to fully participate in all aspects of society, yet many people with physical or mental disabilities have been precluded from doing so because of discrimination; others who have a record of a disability or are regarded as having a disability also have been subjected to discrimination;
(2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;
(3) discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services;
(4) unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;
(5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion...failure to make modifications to existing facilities and practices...segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;
(6) census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally;

(7) the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals; and...
(b) Purpose. It is the purpose of this Act—
(1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
(2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
(3) to ensure that the Federal Government plays a central role in enforcing the standards established in this Act on behalf of individuals with disabilities; and
(4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities....

42 U.S.C. § 12103. Additional definitions

As used in this Act:
(1) Auxiliary aids and services. The term "auxiliary aids and services" includes—...
(C) acquisition or modification of equipment or devices; and
(D) other similar services and actions.

42 U.S.C. § 12188. Enforcement

(a) In general.
(1) Availability of remedies and procedures. The remedies and procedures set forth in section 204(a) of the Civil Rights Act...provides to any person who is being subjected to discrimination on the basis of disability in violation of this title [42 USCS §§ 12181

et seq.] or who has reasonable grounds for believing that such person is about to be subjected to discrimination in violation of section 303 [42 USCS § 12183]. Nothing in this section shall require a person with a disability to engage in a futile gesture if such person has actual notice that a person or organization covered by this title [42 USCS §§ 12181 et seq.] does not intend to comply with its provisions. (2) Injunctive relief...Where appropriate, injunctive relief shall also include requiring the provision of an auxiliary aid or service, modification of a policy, or provision of an auxiliary aid or service, modification of a policy, or provision of alternative methods, to the extent required by this title [42 USCS §§ 12181 et seq.].

42 U.S.C. § 12203. Prohibition against retaliation and coercion

(a) Retaliation. No person shall discriminate against any individual because such individual has opposed any act or practice made unlawful by this Act or because such individual made a charge, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing under this Act. (b) Interference, coercion, or intimidation. It shall be unlawful to coerce, intimidate, threaten, or interfere with any individual in the exercise or enjoyment of, or on account of his or her having exercised or enjoyed, or on account of his or her having aided or encouraged any other individual in the exercise or enjoyment of, any right granted or protected by this Act.

42 U.S.C. § 12205. Attorney's fees

In any action or administrative proceeding commenced pursuant to this Act, the court or agency, in its discretion, may allow the prevailing

party, other than the United States, a reasonable attorney's fee, including litigation expenses, and costs, and the United States shall be liable for the foregoing the same as a private individual.

ADA Regulations

28 C.F.R. § 35.104 Definitions.

For purposes of this part, the term—
(a) Purpose. The purpose of this part is to implement subtitle A of title II of the Americans with Disabilities Act of 1990 (42 U.S.C. 12131–12134), as amended by the ADA Amendments Act of 2008 ...which prohibits discrimination on the basis of disability by public entities.
(b) Broad coverage. The primary purpose of the ADA Amendments Act is to make it easier for people with disabilities to obtain protection under the ADA....The primary object of attention in cases brought under the ADA should be whether entities covered under the ADA have complied with their obligations and whether discrimination has occurred, not whether the individual meets the definition of "disability."...
(a) Except as provided in paragraph (b) of this section, this part applies to all services, programs, and activities provided or made available by public entities.

28 C.F.R. § 35.130 General prohibitions against discrimination.

(1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability—
(i) Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid,

benefit, or service;
(ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
(iii) Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;
(iv) Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;...
(7)(i) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity...
(d) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

28 C.F.R. § 35.134 Retaliation or coercion.
(a) No private or public entity shall discriminate against any individual because that individual has opposed any act or practice made unlawful by this part, or because that individual made a charge, testified, assisted, or participated in any manner in

an investigation, proceeding, or hearing under the Act or this part.
(b) No private or public entity shall coerce, intimidate, threaten, or interfere with any individual in the exercise or enjoyment of, or on account of his or her having exercised or enjoyed, or on account of his or her having aided or encouraged any other individual in the exercise or enjoyment of, any right granted or protected by the Act or this part.

Medicaid Act Regulations

42 C.F.R. 431.10(e) Authority of the single State agency.

The Medicaid agency may not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

42 C.F.R. § 431.51 Free choice of providers.

(a) Statutory basis. This section is based on sections 1902(a)(23), 1902(e)(2), and 1915(a) and (b) and 1932(a)(3) of the Act.
(1) Section 1902(a)(23) of the Act provides that beneficiaries may obtain services from any qualified Medicaid provider that undertakes to provide the services to them...
Notice means a written statement that meets the requirements of § 431.210.
Request for a hearing means a clear expression by the applicant or beneficiary, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority.

42 C.F.R. § 431.205 Provision of hearing system.

(a) The Medicaid agency must be responsible for maintaining a hearing system that meets the

requirements of this subpart.
(b) The State's hearing system must provide for—
(1) A hearing before—
(i) The Medicaid agency; or ...
(2) An evidentiary hearing at the local level, with a right of appeal to the Medicaid agency...
(d) The hearing system must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970), and any additional standards specified in this subpart.
(e) The hearing system must be accessible to persons who are limited English proficient and persons who have disabilities, consistent with § 435.905(b) of this chapter.
(f) The hearing system must comply with the United States Constitution, the Social Security Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and section 1557 of the Affordable Care Act and implementing regulations.

42 C.F.R. § 431.206 Informing applicants and beneficiaries.

(a) The agency must issue and publicize its hearing procedures.
(b) The agency must, at the time specified in paragraph (c) of this section, inform every applicant or beneficiary in writing—
(1) Of his or her right to a fair hearing and right to request an expedited fair hearing;
(2) Of the method by which he may obtain a hearing;
...(4) Of the time frames in which the agency must take final administrative action, in accordance with § 431.244(f).
(c) The agency must provide the information

required in paragraph (b) of this section—
(1) At the time that the individual applies for Medicaid;
(2) At the time the agency denies an individual's claim for eligibility, benefits or services; or denies a request for exemption from mandatory enrollment in an Alternative Benefit Plan; or takes other action, as defined at § 431.201; or whenever a hearing is otherwise required in accordance with § 431.220(a)...

42 C.F.R. § 431.210 Content of notice.

A notice required under § 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain—
(a) A statement of what action the agency...intends to take and the effective date of such action;
(b) A clear statement of the specific reasons supporting 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 a local evidentiary hearing if one is available, or a State agency hearing...

42 C.F.R. § 431.211 Advance notice.

The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214.

§ 431.220 When a hearing is required.

(a) The State agency must grant an opportunity for a hearing to the following:

(1) Any individual who requests it because he or she believes the agency has taken an action erroneously, denied his or her claim for eligibility or for covered benefits or services, or issued a determination of an individual's liability, or has not acted upon the claim with reasonable promptness including, if applicable—...
(iv) A change in the amount or type of benefits or services

42 C.F.R.§ 431.223 Denial or dismissal of request for a hearing.

The agency may deny or dismiss a request for a hearing if—
(a) The applicant or beneficiary withdraws the request...
(b) The applicant or beneficiary fails to appear at a scheduled hearing without good cause.

42 C.F.R. § 431.224 Expedited appeals.

(a) General rule.
(1) The agency must establish and maintain an expedited fair hearing process for individuals to request an expedited fair hearing, if the agency determines that the time otherwise permitted for a hearing under § 431.244(f)(1) could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function.
(2) The agency must take final administrative action within the period of time permitted under § 431.244(f)(3) if the agency determines that the individual meets the criteria for an expedited fair hearing in paragraph (a)(1) of this section.
(b) Notice. The agency must notify the individual whether the request is granted or denied as expeditiously as possible. Such notice must be provided orally or through electronic means in

accordance with § 435.918 of this chapter, if consistent with the individual's election under such section; if oral notice is provided, the agency must follow up with written notice, which may be through electronic means if consistent with the individual's election under § 435.918.

42 C.F.R. § 431.230 Maintaining services.

(a) If the agency sends the 10-day or 5-day notice as required under § 431.211 or § 431.214 of this subpart, 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 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 beneficiary 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 beneficiary to recoup the cost of any services furnished the beneficiary, to the extent they were furnished solely by reason of this section.

42 C.F.R. § 431.231 Reinstating services.

(a) The agency may reinstate services if a beneficiary requests a hearing not more than 10 days after the date of action.

(b) The reinstated services must continue until a hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.

(c) The agency must reinstate and continue services until a decision is rendered after a hearing if—

(1) Action is taken without the advance notice

required under § 431.211 or § 431.214 of this subpart...

42 C.F.R. § 431.240 Conducting the hearing.

(a) All hearings must be conducted—
(1) At a reasonable time, date, and place;
(2) Only after adequate written notice of the hearing; and
(3) By one or more impartial officials or other individuals who have not been directly involved in the initial determination of the action in question.
(b) If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and if the hearing officer considers it necessary to have a medical assessment other than that of the individual involved in making the original decision, such a medical assessment must be obtained at agency expense and made part of the record....

42 C.F.R. 431.241 Matters to be considered at the hearing.

The hearing must cover—
(a) Any matter described in § 431.220(a)(1) for which an individual requests a fair hearing...

42 C.F.R. § 431.242 Procedural rights of the applicant or beneficiary.

The applicant or beneficiary, or his representative, must be given an opportunity to—
(a) Examine at a reasonable time before the date of the hearing and during the hearing:
(1) The content of the applicant's or beneficiary's case file and electronic account, as defined in § 435.4 of this chapter; and
(2) All documents and records to be used by the State or local agency or the skilled nursing facility or

nursing facility at the hearing;
(b) Bring witnesses;
(c) Establish all pertinent facts and circumstances;
(d) Present an argument without undue interference; and
(e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.
(f) Request an expedited fair hearing.

42 C.F.R. § 431.244 Hearing decisions.

(a) Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing.
(b) The record must consist only of—
(1) The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;
(2) All papers and requests filed in the proceeding; and
(3) The recommendation or decision of the hearing officer.
(c) The applicant or beneficiary must have access to the record at a convenient place and time.
(d) In any evidentiary hearing, the decision must be a written one that—
(1) Summarizes the facts; and
(2) Identifies the regulations supporting the decision.
(e) In a de novo hearing, the decision must—
(1) Specify the reasons for the decision; and
(2) Identify the supporting evidence and regulations.
(f) The agency must take final administrative action as follows:
(1) Ordinarily, within 90 days from...
(ii) For all other fair hearings, the date the agency receives a request for a fair hearing in accordance

with § 431.221(a)(1).
(2) As expeditiously as the enrollee's health condition requires...
(i) Meets the criteria for expedited resolution as set forth in § 438.410(a) of this chapter, but was not resolved within the timeframe for expedited resolution; or
(4) (i) The agency must take final administrative action on a fair hearing request within the time limits set forth in this paragraph except in unusual circumstances when—
(A) The agency cannot reach a decision because the appellant requests a delay or fails to take a required action; or
(B) There is an administrative or other emergency beyond the agency's control.
(ii) The agency must document the reasons for any delay in the appellant's record.
(g) The public must have access to all agency hearing decisions, subject to the requirements of subpart F of this part for safeguarding of information.

42 C.F.R. § 431.245 Notifying the applicant or beneficiary of a State agency decision.

The agency must notify the applicant or beneficiary in writing of—
(a) The decision; and
(b) His right to request a State agency hearing or seek judicial review, to the extent that either is available to him.

42 C.F.R. § 431.246 Corrective action.

The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility if—
(a) The hearing decision is favorable to the applicant

or beneficiary; or
(b) The agency decides in the applicant's or beneficiary's favor before the hearing.

42 C.F.R. § 435.901 Consistency with objectives and statutes.

The Medicaid agency's standards and methods for providing information to applicants and beneficiaries and for determining eligibility must be consistent with the objectives of the program and with the rights of individuals under the United States Constitution, the Social Security Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990...

42 C.F.R. § 435.902 Simplicity of administration.

The agency's policies and procedures must ensure that eligibility is determined in a manner consistent with simplicity of administration and the best interests of the applicant or beneficiary.

42 C.F.R. § 435.911 Determination of eligibility.

(a) Statutory basis. This section implements sections 1902(a)(4), (a)(8), (a)(10)(A), (a)(19), and (e)(14) and section 1943 of the Act...
(c) For each individual ...the State Medicaid agency must comply with the following—
(1) The agency must, promptly and without undue delay consistent with timeliness standards established under § 435.912, furnish Medicaid to each such individual whose household income is at or below the applicable modified adjusted gross income standard...

42 C.F.R. § 435.912 Timely determination of eligibility.

(a) For purposes of this section—

(1) "Timeliness standards" refer to the maximum period of time in which every applicant is entitled to a determination of eligibility, subject to the exceptions in paragraph (e) of this section...
(3) Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant may not exceed—
(i) Ninety days for applicants who apply for Medicaid on the basis of disability; and
(ii) Forty-five days for all other applicants.
(d) The agency must inform applicants of the timeliness standards adopted in accordance with this section.
(e) The agency must determine eligibility within the standards except in unusual circumstances, for example—
(1) When the agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or
(2) When there is an administrative or other emergency beyond the agency's control.
(f) The agency must document the reasons for delay in the applicant's case record.
(g) The agency must not use the time standards—
(1) As a waiting period before determining eligibility; or
(2) As a reason for denying eligibility (because it has not determined eligibility within the time standards)...

42 C.F.R. § 435.930 Furnishing Medicaid.

The agency must—
(a) Furnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures;
(b) Continue to furnish Medicaid regularly to all

eligible individuals until they are found to be ineligible...

42 C.F.R. 441.18 Case management services.

(a) If a State plan provides for case management services (including targeted case management services), as defined in § 440.169 of this chapter, the State must meet the following requirements:

(1) Allow individuals the free choice of any qualified Medicaid provider within the specified geographic area identified in the plan when obtaining case management services, in accordance with § 431.51 of this chapter, except as specified in paragraph (b) of this section.

(2) Not use case management (including targeted case management) services to restrict an individual's access to other services under the plan.

(3) Not compel an individual to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services...

(6) Prohibit providers of case management services from exercising the agency's authority to authorize or deny the provision of other services under the plan.

(7) Require providers to maintain case records that document for all individuals receiving case management as follows:

(i) The name of the individual.

(ii) The dates of the case management services.

(iii) The name of the provider agency (if relevant) and the person providing the case management service.

(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.
(v) Whether the individual has declined services in the care plan.
(vi) The need for, and occurrences of, coordination with other case managers.
(vii) A timeline for obtaining needed services.
(viii) A timeline for reevaluation of the plan...

42 C.F.R. § 441.301 Contents of request for a waiver.

(a) A request for a waiver under this section must consist of the following:
(1) The assurances required by § 441.302 and the supporting documentation required by § 441.303...
(b) If the agency furnishes home and community-based services, as defined in § 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must—
(1) Provide that the services are furnished—
(i) Under a written person-centered service plan (also called plan of care) that is based on a person-centered approach and is subject to approval by the Medicaid agency.
...(iii) Only to beneficiaries who the agency determines would, in the absence of these services, require the Medicaid covered level of care provided in—
(A) A hospital (as defined in § 440.10 of this chapter);
(B) A NF (as defined in section 1919(a) of the Act); or
(C) An ICF/IID (as defined in § 440.150 of this chapter);
(2) Describe the qualifications of the individual or individuals who will be responsible for developing the individual plan of care;

(3) Describe the group or groups of individuals to whom the services will be offered;
(4) Describe the services to be furnished so that each service is separately defined. Multiple services that are generally considered to be separate services may not be consolidated under a single definition. Commonly accepted terms must be used to describe the service and definitions may not be open ended in scope. CMS will, however, allow combined service definitions (bundling) when this will permit more efficient delivery of services and not compromise either a beneficiary's access to or free choice of providers.
(5) Provide that the documentation requirements regarding individual evaluation, specified in § 441.303(c), will be met; and...
(c) A waiver request under this subpart must include the following—
(1) Person-centered planning process. The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:
(i) Includes people chosen by the individual.
(ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
(iii) Is timely and occurs at times and locations of

convenience to the individual.
...(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan...Individuals must be provided with a clear and accessible alternative dispute resolution process.
(vii) Offers informed choices to the individual regarding the services and supports they receive and from whom.
(viii) Includes a method for the individual to request updates to the plan as needed.
(ix) Records the alternative home and community-based settings that were considered by the individual.
(2) The Person-Centered Service Plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:
(i) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community,

including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
(ii) Reflect the individual's strengths and preferences.
(iii) Reflect clinical and support needs as identified through an assessment of functional need.
(iv) Include individually identified goals and desired outcomes.
(v) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.
(vi) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed...
(viii) Identify the individual and/or entity responsible for monitoring the plan.
(ix) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
(x) Be distributed to the individual and other people involved in the plan.
(xi) Include those services, the purpose or control of which the individual elects to self-direct.
(xii) Prevent the provision of unnecessary or inappropriate services and supports.
(xiii) Document that any modification of the

additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
(A) Identify a specific and individualized assessed need.
(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(C) Document less intrusive methods of meeting the need that have been tried but did not work.
(D) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(E) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(G) Include informed consent of the individual.
(H) Include an assurance that interventions and supports will cause no harm to the individual.
(3) Review of the Person-Centered Service Plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.
(4) Home and Community-Based Settings. Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the

needs of the individual as indicated in their person-centered service plan:
(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
(ii) The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
(v) Facilitates individual choice regarding services and supports, and who provides them...

42 C.F.R. § 441.302 State assurances.

Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted:
(a) Health and Welfare —Assurance that necessary safeguards have been taken to protect the health

and welfare of the beneficiaries of the services. Those safeguards must include— ...
(5) Assurance that services are provided in home and community based settings, as specified in § 441.301(c)(4).
(b) Financial accountability— The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.
(c) Evaluation of need. Assurance that the agency will provide for the following:
...(2) Periodic reevaluations. Reevaluations, at least annually, of each beneficiary receiving home or community-based services to determine if the beneficiary continues to need the level of care provided...
(d) Alternatives —Assurance that when a beneficiary is determined to be likely to require the level of care provided in a hospital, NF, or ICF/IID, the beneficiary or his or her legal representative will be—
(1) Informed of any feasible alternatives available under the waiver; and
(2) Given the choice of either institutional or home and community-based services...
(g) Institutionalization absent waiver. Assurance that, absent the waiver, beneficiaries in the waiver would receive the appropriate type of Medicaid-funded institutional care (hospital, NF, or ICF/IID)

that they require...

42 C.F.R. § 441.715 Needs-based criteria and evaluation.

(a) Needs-based criteria. The State must establish needs-based criteria for determining an individual's eligibility under the State plan for the HCBS benefit, and may establish needs-based criteria for each specific service. Needs-based criteria are factors used to determine an individual's requirements for support, and may include risk factors. The criteria are not characteristics that describe the individual or the individual's condition. A diagnosis is not a sufficient factor on which to base a determination of need. A criterion can be considered needs-based if it is a factor that can only be ascertained for a given person through an individualized evaluation of need...

(d) Independent evaluation and determination of eligibility. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of this subpart. The independent evaluation complies with the following requirements:

(1) Is performed by an agent that is independent and qualified as defined in § 441.730.

(2) Applies the needs-based eligibility criteria that the State has established under paragraph (a) of this section, and the general eligibility requirements under §§ 435.219 and 436.219 of this chapter.

(3) Includes consultation with the individual, and if applicable, the individual's representative as defined under § 441.735.

(4) Assesses the individual's support needs.

(5) Uses only current and accurate information from existing records, and obtains any additional

information necessary to draw valid conclusions about the individual's support needs.
(6) Evaluations finding that an individual is not eligible for the State plan HCBS benefit are treated as actions defined in § 431.201 of this chapter and are subject to the requirements of part 431 subpart E of this chapter.
(e) Periodic redetermination. Independent reevaluations of each individual receiving the State plan HCBS benefit must be performed at least every 12 months, to determine whether the individual continues to meet eligibility requirements. Redeterminations must meet the requirements of paragraph (d) of this section.

42 C.F.R. § 441.720 Independent assessment.
(a) Requirements. For each individual determined to be eligible for the State plan HCBS benefit, the State must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan. In applying the requirements of section 1915(i)(1)(F) of the Act, the State must:
(1) Perform a face-to-face assessment of the individual by an agent who is independent and qualified as defined in § 441.730, and with a person-centered process that meets the requirements of § 441.725(a) and is guided by best practice and research on effective strategies that result in improved health and quality of life outcomes.
(i) For the purposes of this section, a face-to-face assessment may include assessments performed by telemedicine, or other information technology medium, if the following conditions are met:
(A) The agent performing the assessment is

independent and qualified as defined in § 441.730 and meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology.
(B) The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff.
(C) The individual provides informed consent for this type of assessment...
(2) Conduct the assessment in consultation with the individual, and if applicable, the individual's authorized representative, and include the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals responsible for the individual's care.
(3) Examine the individual's relevant history including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the person-centered service plan as required in § 441.725.
(4) Include in the assessment the individual's physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service and housing options, and if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment.
(5) For each service, apply the State's additional needs-based criteria (if any) that the individual may require. Individuals are considered enrolled in the State plan HCBS benefit only if they meet the

eligibility and needs-based criteria for the benefit, and are also assessed to require and receive at least one home and community-based service offered under the State plan for medical assistance...
(b) Reassessments. The independent assessment of need must be conducted at least every 12 months and as needed when the individual's support needs or circumstances change significantly, in order to revise the service plan.

42 C.F.R. § 441.725 Person-centered service plan.

(a) Person-centered planning process. Based on the independent assessment required in § 441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The person-centered planning process is driven by the individual. The process:
(1) Includes people chosen by the individual.
(2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
(3) Is timely and occurs at times and locations of convenience to the individual.
...(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
(6) Offers choices to the individual regarding the services and supports the individual receives and from whom.
(7) Includes a method for the individual to request

updates to the plan, as needed.
(8) Records the alternative home and community-based settings that were considered by the individual.
(b) The person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit, the written plan must:
(1) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
(2) Reflect the individual's strengths and preferences.
(3) Reflect clinical and support needs as identified through an assessment of functional need.
(4) Include individually identified goals and desired outcomes.
(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural

supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS.
(6) Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.
(8) Identify the individual and/or entity responsible for monitoring the plan.
(9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
(10) Be distributed to the individual and other people involved in the plan.
(11) Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of § 441.740.
(12) Prevent the provision of unnecessary or inappropriate services and supports.
(13) Document that any modification of the additional conditions, under § 441.710(a)(1)(vi)(A) through (D) of this chapter, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
(i) Identify a specific and individualized assessed

need.
(ii) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(iii) Document less intrusive methods of meeting the need that have been tried but did not work.
(iv) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
(vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(vii) Include informed consent of the individual; and
(viii) Include an assurance that the interventions and supports will cause no harm to the individual.
(c) Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required in § 441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

42 C.F.R. § 441.730 Provider qualifications.

(a) Requirements. The State must provide assurances that necessary safeguards have been taken to protect the health and welfare of enrollees in State plan HCBS, and must define in writing standards for providers (both agencies and individuals) of HCBS and for agents conducting individualized independent evaluation, independent assessment, and service plan development.
(b) Conflict of interest standards. The State must define conflict of interest standards that ensure the

independence of individual and agency agents who conduct (whether as a service or an administrative activity) the independent evaluation of eligibility for State plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan. The conflict of interest standards apply to all individuals and entities, public or private...
(c) Training. Qualifications for agents performing independent assessments and plans of care must include training in assessment of individuals whose physical, cognitive, or mental conditions trigger a potential need for home and community-based services and supports, and current knowledge of available resources, service options, providers, and best practices to improve health and quality of life outcomes.

42 C.F.R. § 441.745 State plan HCBS administration: State responsibilities and quality improvement.

(a) State plan HCBS administration —
(1) State responsibilities. The State must carry out the following responsibilities in administration of its State plan HCBS: ...
(ii) Access to services. The State must grant access to all State plan HCBS assessed to be needed in accordance with a service plan consistent with § 441.725, to individuals who have been determined to be eligible for the State plan HCBS benefit, subject to the following requirements:
(A) A State must determine that provided services meet medical necessity criteria.
(B) A State may limit access to services through targeting criteria established by § 441.710(e)(2).

(C) A State may not limit access to services based upon the income of eligible individuals, the cost of services, or the individual's location in the State.
(iii) Appeals. A State must provide individuals with advance notice of and the right to appeal terminations, suspensions, or reductions of Medicaid eligibility or covered services as described in part 431, subpart E.

State Medicaid Manual
STATE ORGANIZATION AND GENERAL ADMINISTRATION

2900 FAIR HEARINGS AND APPEALS

Section 1902(a)(3) of the Social Security Act requires that States "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." Regulations implementing this section of law are found at 42 CFR 431 Subpart E. In addition, certain court decisions further amplify and modify the law and regulations governing the provision of notices and hearings to Medicaid applicants and recipients. Where appropriate, those decisions are cited .

2900.1 Basic Responsibility (42 CFR 431.200 and 431.205).
Establish policies and procedures for assuring a system of fair hearings that meet all the requirements of the regulations and instructions.

Notify and make available to the applicant or recipient the hearing procedures required by regulations and these instructions, if any of the

following events occur:

- denial of eligibility,
- the claim is not acted upon with reasonable promptness,
- termination of eligibility or covered services,
- suspension of eligibility or covered services, or
- reduction of eligibility or covered service

2900. Publication And Distribution Of Hearing Procedures (42 CFR 431.206(a)).

Issue and publicize your hearing procedures.

The publication and wide distribution of hearing procedures in the form of rules and regulations or a clearly stated pamphlet to appellants, recipients, and other interested groups and individuals helps to emphasize the purposes and importance of the procedure and to inform aggrieved individuals about the existence and use of this procedure. It not only contributes to the fairness and orderliness of the hearing, but also emphasizes the principles of equity and due process throughout the administration of medical assistance.

2900.4 Informing Individuals of their Appeal Rights (42 CFR 431.206).--Notify in writing any applicant or recipient of the right to a hearing and the procedure for requesting a hearing at the time of application and at the time of any action by the agency. (See §2900.1 defining the action requiring Notice of Appeal Rights.)

You may give written notification on the application form or on other forms you routinely send to applicants and recipients. If you publish an agency pamphlet describing the provisions of your Medicaid program, include an explanation of the applicant's and recipient's appeal rights...

2901.NOTICE AND OPPORTUNITY FOR A FAIR HEARING

2901.1Advance Notice of Intent to Terminate, Reduce or Suspend Medicaid (42 CFR 431.211 and 431.213).

A. Advance Notice.

1. 10-Day Advance Notice.--Whenever you propose to terminate, reduce or suspend Medicaid covered services, mail advance notice of the pending action to the recipient at least 10 days prior to the time of the anticipated action, except as provided in subsections A2 and B. With respect to eligibility factors known in advance, such as attainment of age 18 or increased hours or wages of employment, (42 CFR 435.112), send the notice even earlier, thus allowing more time to resolve any issue or questions.

2. 30-Day Advance Notice.--Give an applicant or recipient 30 days advance notice whenever you propose to deny, terminate, reduce, or suspend eligibility or covered services because of data disclosed through a matching program covered under the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503).

2901.3

B. Less Than 10 days Advance Notice.--In the following circumstances advance notice may be reduced or is not necessary. Advance notice may be reduced to 5 days in cases where you have facts indicating action should be taken because of probable fraud by the recipient....

2901.3 Opportunity for a Fair Hearing --All applicants and recipients sent a notice as required by §2901.1 may request a Fair Hearing. Except as provided elsewhere in this section grant a timely request for a hearing and render a decision in the

name of the agency...

2902 HEARINGS

2902.1 Request for a Hearing

A request for a hearing must be in writing and signed by the applicant or recipient, or the authorized representative of the applicant/recipient. In the case of authorized representatives, you must have evidence that the individual claiming to represent the applicant/recipient has been authorized to do so.

Oral inquiries about the opportunity to appeal should be treated as requests for appeal for purposes of establishing the earliest possible date for an appeal.

If you provide a conference to applicants or recipients who have been sent notices of action the applicant may request a hearing without first having a conference and such conference may not substitute for the hearing.

Promptly acknowledge every hearing request received.

2902.2Continuation and Reinstatement of Services Pending a Hearing Decision

A. Required Continuation or Reinstatement.--Continue to provide or reinstate Medicaid services until a hearing decision has been rendered in the following circumstances.

1. Continue Services.--If you mail the 10 day or 5 day notice as required and the recipient requests a hearing before the date of action, continue Medicaid services.

2. Reinstate services if:

o You take action without the advance notice required;

o The recipient's whereabouts are unknown

(agency mail is returned as undeliverable) but during the time the recipient is eligible for services the recipient§s whereabouts become known, or

- The recipient requests a hearing within 10 days of mailing the notice of action; and
- You determine that the action results from other than the application of Federal or State law or policy.

...C. When Maintained for Reinstated Services May be Stopped.--You must continue to provide services maintained or reinstated after an appeal until a hearing decision is rendered unless the hearing officer, at the hearing, determines that the sole issue is one of Federal or State law or policy. When the hearing officer determines the appeal is one of law or policy, you may discontinue services but only after promptly informing the recipient in writing that services will be discontinued pending the hearing decision.

2902.3 Dismissal of A Hearing Request.

A. Dismissal.--You may dismiss a request for a hearing when:

- The claimant or his representative requests in writing that the request for hearing be withdrawn; or
- The claimant abandons his right to a hearing as described in subsection B.

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

2902.8Claimant's Right To A Different Medical Assessment (42 CFR 431.240(b)).

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

2902.9 Rights Of Claimants During Hearings (42 CFR 431.242).

Provide the appellant or his representative an opportunity to examine all materials to be used at the hearing. Non-record or confidential information which the claimant or his representative does not have the opportunity to see is not made a part of the hearing record or used in a decision on an appeal. If the hearing officer reviews the case record, or other material, including the hearing summary proposal by agency staff, such material must also be made available to the appellant or his representative. The hearing officer must enable the appellant and his witnesses to give all evidence on points at issue and the appellant and his representative to advance arguments without undue interference. Give the appellant the opportunity to confront and cross-examine witnesses at the hearing and to present

evidence in rebuttal. Do not use application of the rules for the conduct of the hearing to suppress the appellant's claim. ...

2902.10 Prompt, Definitive And Final Action (42 CFR 431.244(f).

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

2903. HEARING DECISION

2903.1Basis for Hearing Officer Recommendation, Decision, And Opportunity to Examine Offical Record (42 CFR 431.244).

The hearing officer's recommendation or decision shall be based only on the evidence and testimony introduced at the hearing. The record of the proceedings, which consists of the transcript or recording of the hearing testimony, any exhibits, papers or requests filed in the appeal, including the documents and reasons upon which the determination being appealed is based, and the hearing officer's written recommendation or decision shall be available to the claimant or his

representative at a convenient time and at a place accessible to him or his representative, to examine upon request. If any additional material is made part of the hearing record it too shall be made available.

2903.2Hearing Decision And Notification to Claimant
(42 CFR 431.232, 233, 244(b)and(d) and 431.245).

A. General.--A conclusive decision in the name of the State agency shall be made by the hearing authority. That authority may be the highest executive officer of the State agency, a panel of agency officials, or an offical appointed for the purpose. No person who has previously participated at any level in the determination upon which the final decision is based may participate in the decision. For example, a person who participated in the original determination being appealed may not participate in the appeal; nor may a person who participated in a local hearing participate in the agency hearing.

The officially designated hearing authority may adopt the recommendations of the hearing officer, or reject them and reach a different conclusion on the basis of the evidence, or refer the matter back to the hearing officer for a resumption of the hearing if the materials submitted are insufficient to serve as basis for a decision except where the appeal involves the issue of disability and SSA has issued a disability determination which is binding on the program. Remanding the case to the local unit for further consideration is not a substitute for "definitive and final administrative action."

B. Hearing Records.--All hearing recommendations or decisions must be based

exclusively on evidence introduced at the hearing. The record must consist only of:

- The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing; and
- All papers and requests filed during the appeal; and
- The recommendation or decision of the hearing officer...

2903.3 State Agency Responsibility In Carrying Out The Hearing Decision (42 CFR 431.244(f)).

A. General.--The hearing authority's decision is binding upon the State and Local agencies. You are responsible for assuring that the decision is carried out promptly. Various methods, such as report by the local agency on action taken, or follow-up by State office staff, may be used.

B. Final Administrative Action.--Section 431.244(f) requires that you take final administrative action within 90 days of the request for hearing. In implementing this regulation it is reasonable to allow additional time to meet this standard when a delay beyond 90 days is due to claimant requests or untimely receipt by the hearing authority of documentation needed to render a decision which had been requested timely. Any delay can not exceed 30 days.

C. Corrective Action--If the hearing decision is favorable to the claimant, or if the agency decides in favor of the claimant prior to a hearing, promptly take action to reinstate Medicaid eligibility and process any unpaid providers claims within the standard set forth in B.

Department of Justice Olmstead Statement (2011)

Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.

In the years since the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), the goal of the integration mandate in title II of the Americans with Disabilities Act – to provide individuals with disabilities opportunities to live their lives like individuals without disabilities – has yet to be fully realized. Some state and local governments have begun providing more integrated community alternatives to individuals in or at risk of segregation in institutions or other segregated settings. Yet many people who could and want to live, work, and receive services in integrated settings are still waiting for the promise of Olmstead to be fulfilled.

In 2009, on the tenth anniversary of the Supreme Court's decision in Olmstead, President Obama launched "The Year of Community Living" and directed federal agencies to vigorously enforce the civil rights of Americans with disabilities. Since then, the Department of Justice has made enforcement of Olmstead a top priority. As we commemorate the 12th anniversary of the Olmstead decision, the Department of Justice reaffirms its commitment to vindicate the right of individuals with disabilities to live integrated lives under the ADA and Olmstead. To assist individuals in understanding their rights under title II of the ADA and its integration mandate, and to assist state and local governments in complying with the ADA, the

Department of Justice has created this technical assistance guide.

The ADA and Its Integration Mandate

In 1990, Congress enacted the landmark Americans with Disabilities Act "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[1] In passing this groundbreaking law, Congress recognized that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."[2] For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.[3]

As directed by Congress, the Attorney General issued regulations implementing title II, which are based on regulations issued under section 504 of the Rehabilitation Act.[4] The title II regulations require

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[1] 42 U.S.C. § 12101(b)(1).

[2] 42 U.S.C. § 12101(a)(2).

[3] 42 U.S.C. § 12132.

[4] See 42 U.S.C. § 12134(a); 28 C.F.R. § 35.190(a); Executive Order 12250, 45 Fed. Reg. 72995 (1980), reprinted in 42 U.S.C. § 2000d 1. Section 504 of the

public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[5] The preamble discussion of the "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible . . . ."[6]

In Olmstead v. L.C., 527 U.S. 581 (1999), the Supreme Court held that title II prohibits the unjustified segregation of individuals with disabilities.

The Supreme Court held that public entities are required to provide community based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community based treatment; and (c) community based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity.[7] The Supreme

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Rehabilitation Act of 1973 similarly prohibits disability based discrimination. 29 U.S.C § 794(a) ("No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistancate . . . ."). Claims under the ADA and the Rehabilitation Act are generally treated identically.

[5] 28 U.S.C. § 35.130(d) (the "integration mandate").

[6] 28 C.F.R. Pt. 35, App. A (2010) (addressing § 35.130).

[7] Olmstead v. L.C., 527 U.S.C. at 607.

Court explained that this holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."

Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[8]

To comply with the ADA's integration mandate, public entities must reasonably modify their policies, procedures or practices when necessary to avoid discrimination.[9] The obligation to make reasonable modifications may be excused only where the public entity demonstrates that the requested modifications would "fundamentally alter" its service system.[10]
In the years since the passage of the ADA and the Supreme Court's decision in Olmstead, the ADA's integration mandate has been applied in a wide variety of contexts and has been the subject of substantial litigation. The Department of Justice has created this technical assistance guide to assist individuals in understanding their rights and public entities in understanding their obligations under the ADA and Olmstead. This guide catalogs and explains the positions the Department of Justice has taken in its Olmstead enforcement. It reflects the

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[8] Id. at 600 01.

[9] 28 C.F.R. § 35.130(b)(7).

[10] Id.; see also Olmstead, 527 U.S. at 604.07.

views of the Department of Justice only. For questions about this guide, you may contact our ADA Information Line, 8005140301 (voice), 8005140383 (TTY).
Date: June 22, 2011

Questions and Answers on the ADA's Integration Mandate and Olmstead Enforcement

1. What is the most integrated setting under the ADA and Olmstead?

A: The "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[11] Integrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities. Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with nondisabled persons to the fullest extent possible...

2. When is the ADA's integration mandate implicated?

A: The ADA's integration mandate is implicated where a public entity administers its programs in a manner that results in unjustified segregation of persons with disabilities. More specifically, a public entity may violate the ADA's integration mandate

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[11] 28 C.F.R. pt. 35 app. A (2010).

when it: (1) directly or indirectly operates facilities and or/programs that segregate individuals with disabilities; (2) finances the segregation of individuals with disabilities in private facilities; and/or (3) through its planning, service system design, funding choices, or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs.[12]

3. Does a violation of the ADA's integration mandate require a showing of facial discrimination?

A: No, in the Olmstead context, an individual is not required to prove facial discrimination. In Olmstead, the court held that the plaintiffs could make out a case under the integration mandate even if they could not prove "but for" their disability, they would have received the community based services they sought. It was enough that the state currently provided them services in an institutional setting that was not the most integrated setting appropriate.[13] Additionally, an Olmstead claim is distinct from a claim of disparate treatment or

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[12] See 29 C.F.R. § 35.130(b)(1) (prohibiting a public entity from discriminating "directly or through contractual, licensing or other arrangements, on the basis of disability"); § 35.130(b)(2) (prohibiting a public entity from "directly, or through contractual or other arrangements, utilizing criteria or methods of administration" that have the effect of discriminating on the basis of disability").

[13] Olmstead, 527 U.S. at 598; 28 C.F.R. 35.130(d).

disparate impact and accordingly does not require proof of those forms of discrimination.

4. What evidence may an individual rely on to establish that an integrated setting is appropriate?

A: An individual may rely on a variety of forms of evidence to establish that an integrated setting is appropriate. A reasonable, objective assessment by a public entity's treating professional is one, but only one, such avenue. Such assessments must identify individuals' needs and the services and supports necessary for them to succeed in an integrated setting. Professionals involved in the assessments must be knowledgeable about the range of supports and services available in the community. However, the ADA and its regulations do not require an individual to have had a state treating professional make such a determination. People with disabilities can also present their own independent evidence of the appropriateness of an integrated setting, including, for example, that individuals with similar needs are living, working and receiving services in integrated settings with appropriate supports. This evidence may come from their own treatment providers, from community based organizations that provide services to people with disabilities outside of institutional settings, or from any other relevant source. Limiting the evidence on which Olmstead plaintiffs may rely would enable public entities to circumvent their Olmstead requirements by failing to require professionals to make recommendations regarding the ability of individuals to be served in more integrated settings...

6. Do the ADA and Olmstead apply to persons at serious risk of institutionalization or segregation?

A: Yes, the ADA and the Olmstead decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings. Individuals need not wait until the harm of institutionalization or segregation occurs or is imminent. For example, a plaintiff could show sufficient risk of institutionalization to make out an Olmstead violation if a public entity's failure to provide community services or its cut to such services will likely cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution.

7. May the ADA and Olmstead require states to provide additional services, or services to additional individuals, than are provided for in their Medicaid programs?

A: A state's obligations under the ADA are independent from the requirements of the Medicaid program.[14] Providing services beyond what a state currently provides under Medicaid may not cause a fundamental alteration, and the ADA may require states to provide those services, under certain circumstances. For example, the fact that a state is permitted to "cap" the number of individuals it serves in a particular waiver program under the Medicaid Act does not exempt the state from serving additional people in the community to comply with

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[14] See CMS, Olmstead Update No. 4, at 4 (Jan. 10, 2001), available at https://www.cms.gov/smdl/downloads/smd011001a.pdf.

the ADA or other laws.[15]

8. Do the ADA and Olmstead require a public entity to provide services in the community to persons with disabilities when it would otherwise provide such services in institutions?

A: Yes. Public entities cannot avoid their obligations under the ADA and Olmstead by characterizing as a "new service" services that they currently offer only in institutional settings. The ADA regulations make clear that where a public entity operates a program or provides a service, it cannot discriminate against individuals with disabilities in the provision of those services.[16] Once public entities choose to provide certain services, they must do so in a nondiscriminatory fashion.[17]

9. Can budget cuts violate the ADA and Olmstead?

A: Yes, budget cuts can violate the ADA and Olmstead when significant funding cuts to community services create a risk of institutionalization or segregation. The most obvious example of such a risk is where budget cuts require the elimination or reduction of community services specifically designed for individuals who would be institutionalized without such services. In making such budget cuts, public entities have a duty to take all reasonable steps to avoid placing individuals at

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[15] Id.

[16] 28 C.F.R. § 35.130.

[17] See U.S. Dept. of Justice, ADA Title II Technical Assistance Manual § II 3.6200.

risk of institutionalization. For example, public entities may be required to make exceptions to the service reductions or to provide alternative services to individuals who would be forced into institutions as a result of the cuts. If providing alternative services, public entities must ensure that those services are actually available and that individuals can actually secure them to avoid institutionalization.

10. What is the fundamental alteration defense?

A: A public entity's obligation under Olmstead to provide services in the most integrated setting is not unlimited. A public entity may be excused in instances where it can prove that the requested modification would result in a "fundamental alteration" of the public entity's service system. A fundamental alteration requires the public entity to prove "that, in the allocation of available resources, immediate relief for plaintiffs would be inequitable, given the responsibility the State [or local government] has taken for the care and treatment of a large and diverse population of persons with [ ] disabilities."[18] It is the public entity's burden to establish that the requested modification would fundamentally alter its service system.

11. What budgetary resources and costs are relevant to determine if the relief sought would constitute a fundamental alteration?

A: The relevant resources for purposes of evaluating a fundamental alteration defense consist of all money the public entity allots, spends, receives, or could receive if it applied for available federal

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[18] Olmstead, 527 U.S. at 604.

funding to provide services to persons with disabilities. Similarly, all relevant costs, not simply those funded by the single agency that operates or funds the segregated or integrated setting, must be considered in a fundamental alteration analysis.

Moreover, cost comparisons need not be static or fixed. If the cost of the segregated setting will likely increase, for instance due to maintenance, capital expenses, environmental modifications, addressing substandard care, or providing required services that have been denied, these incremental costs should be incorporated into the calculation. Similarly, if the cost of providing integrated services is likely to decrease over time, for instance due to enhanced independence or decreased support needs, this reduction should be incorporated as well. In determining whether a service would be so expensive as to constitute a fundamental alteration, the fact that there may be transitional costs of converting from segregated to integrated settings can be considered, but it is not determinative. However, if a public entity decides to serve new individuals in segregated settings ("backfilling"), rather than to close or downsize the segregated settings as individuals in the plaintiff class move to integrated settings, the costs associated with that decision should not be included in the fundamental alteration analysis.

12. What is an Olmstead Plan?

A: An Olmstead plan is a public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings. A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options or

describe the entity's general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities. The plan must have specific and reasonable timeframes and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan, which may come from reallocating existing service dollars. The plan should include commitments for each group of persons who are unnecessarily segregated, such as individuals residing in facilities for individuals with developmental disabilities, psychiatric hospitals, nursing homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs. To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan. A public entity cannot rely on its Olmstead plan as part of its defense unless it can prove that its plan comprehensively and effectively addresses the needless segregation of the group at issue in the case. Any plan should be evaluated in light of the length of time that has passed since the Supreme Court's decision in Olmstead, including a factspecific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future.

13. Can a public entity raise a viable fundamental alteration defense without having implemented an Olmstead plan?

A: The Department of Justice has interpreted the

ADA and its implementing regulations to generally require an Olmstead plan as a prerequisite to raising a fundamental alteration defense, particularly in cases involving individuals currently in institutions or on waitlists for services in the community . In order to raise a fundamental alteration defense, a public entity must first show that it has developed a comprehensive, effectively working Olmstead plan that meets the standards described above. The public entity must also prove that it is implementing the plan in order to avail itself of the fundamental alteration defense. A public entity that cannot show it has and is implementing a working plan will not be able to prove that it is already making sufficient progress in complying with the integration mandate and that the requested relief would so disrupt the implementation of the plan as to cause a fundamental alteration.

14. What is the relevance of budgetary shortages to a fundamental alteration defense?
A: Public entities have the burden to show that immediate relief to the plaintiffs would effect a fundamental alteration of their program. Budgetary shortages are not, in and of themselves, evidence that such relief would constitute a fundamental alteration. Even in times of budgetary constraints, public entities can often reasonably modify their programs by reallocating funding from expensive segregated settings to cost effective integrated settings. Whether the public entity has sought additional federal resources available to support the provision of services in integrated settings for the particular group or individual requesting the modification – such as Medicaid, Money Follows the Person grants, and federal housing vouchers – is also

relevant to a budgetary defense.

15. What types of remedies address violations of the ADA's integration mandate?

A: A wide range of remedies may be appropriate to address violations of the ADA and Olmstead, depending on the nature of the violations.

Remedies typically require the public entity to expand the capacity of community based alternatives by a specific amount, over a set period of time.

Remedies should focus on expanding the most integrated alternatives. For example, in cases involving residential segregation in institutions or large congregate facilities, remedies should provide individuals opportunities to live in their own apartments or family homes, with necessary supports.

Remedies should also focus on expanding the services and supports necessary for individuals' successful community tenure. Olmstead remedies should include, depending on the population at issue: supported housing, Home and Community Based Services ("HCBS") waivers,[19] crisis services, Assertive Community Treatment ("ACT") teams, case management, respite, personal care services, peer support services, and supported employment. In addition, court orders and settlement agreements have typically required public entities to implement a process to ensure that currently segregated individuals are provided information about the

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[19] HCBS waivers may cover a range of services, including residential supports, supported employment, respite, personal care, skilled nursing, crisis services, assistive technology, supplies and equipment, and environmental modifications.

alternatives to which they are entitled under the agreement, given opportunities that will allow them to make informed decisions about their options (such as visiting community placements or programs, speaking with community providers, and meeting with peers and other families), and that transition plans are developed and implemented when individuals choose more integrated settings...

Department of Justice Olmstead Statement (2020)

See https://www.ada.gov/resources/olmstead-mandate-statement/#:~:text=Since%20then%2C%20the%20Department%20of%20Justice%20has%20made,live%20integrated%20lives%20under%20the%20ADA%20and%20Olmstead.

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